PUBLIC HEALTH NURSING

JULY
1944

Biennial Convention

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

NOPHN Resolves—

NOPHN's Thirteenth Biennial Convention opened on June 6 in an atmosphere of tense concern and watchful waiting, since at 1 a.m. on that historic morning the Armed Forces of the Allies landed on the beaches of the Normandy Coast. *What can public health nurses do to win the war and win the peace* was the strong undercurrent theme of all the sessions, with enthusiasm and determination rising with each succeeding day. The resolutions adopted by the membership at the concluding meeting are evidence of public health nurses' full acceptance of their responsibility for service to all the people, evidence of their growing understanding of the part they can play in solving the great social problems of the day. Decidedly the emphasis of the Convention was upon what public health nurses *give* rather than upon what they *get* in tangible return.

Every NOPHN member will want to read and ponder the ten resolutions adopted which chart the course of public health nursing thought and action for the next biennium:

I. WHEREAS, it is fully appreciated that the difficulties of planning and managing a convention in wartime are unusually great:

THEREFORE, we, the members of the National Organization for Public Health Nursing, wish to thank all those who made this meeting possible—the New York State Nurses' Association and especially its District I and its Public Health Nursing Section, the Buffalo Visiting Nurse Association, the Local Arrangements Committee and subcommittees, the Convention Bureau, the exhibitors, and the Memorial Auditorium. We thank also the agencies which realized the importance of this Convention and readjusted their programs to make it possible to send representatives. We thank all those who presented reports and papers.

II. WHEREAS, the program of the National Organization in the last biennium was carried on during the trying period of our initiation into war conditions, and the membership has deeply appreciated the sensitive and gracious leadership of the retiring president, Marion G. Howell, who, in addition to the other heavy burdens she has carried, has given so generously of herself in our service,

THEREFORE, we tender Miss Howell our heartfelt thanks. We thank also Ruth Houlton, NOPHN general director, and the members of the professional staff for meeting the many exigencies of the moment with wisdom and resource; and the business staff for their efficient and devoted service and willingness to adjust to unusual demands.

III. WHEREAS, the war has heightened our consciousness of the need for essential health services and led to overall planning for their equitable distribution, and

In 1943, according to the annual count of the United States Public Health Service, there were 826 counties and 28 cities with no public health nursing services, and

In counties and cities having such service there are many gaps because public health nursing is often limited to one or more specialized areas of work, be it therefore

RESOLVED, that the NOPHN express its belief

1. That a broad, national plan is

needed to make public health nursing available to every citizen, whether in urban or rural communities, and regardless of economic status, creed, or race.

2. That such a plan be related to the proposal of the American Public Health Association that a local health service unit be provided for every 50,000 of population, located in an area in which no point is more than 25 to 40 miles distant from a central headquarters, and that the minimum ratio in this proposed unit of 1 public health nurse to each 5,000 population be expanded to 1 public health nurse to 2,000 or 2,500 in order to supply a complete family service, including nursing care of the sick in their homes.

This would require an increase in the present 21,000 public health nurses to between 60,000 and 65,000.

3. That there be greater coordination of the public health nursing activities of voluntary and official agencies in each community.

IV. WHEREAS, the securing of necessary funds and personnel for the expansion and distribution of public health nursing service is dependent upon its interpretation to the public, therefore be it

RESOLVED, that the NOPHN recommend again the establishment of advisory committees to the nursing services of health departments, schools, and industries; and the broadening of membership of all boards and committees to make them fully representative of various interested groups in the community, including the consumers of public health nursing service.

That the NOPHN also recommend a more active interpretation of public health nursing to the whole nursing profession and to related professional groups, especially the medical profession; and the development of closer relationships with hospitals through cooperative systems for the referral of cases and the reporting to hospitals of the findings and work of public health nurses.

V. WHEREAS, the war has brought into clearer focus for all of us the principles of democracy and the need for all types of people to make their contribution to the common good, be it

RESOLVED, that members of the NOPHN use their influence in the course of daily contacts to bring about elimination of discrimination against racial and minority groups.

VI. WHEREAS, future public health nursing depends on an adequate supply of well-prepared public health nurses, be it

RESOLVED, that the NOPHN participate in an active recruitment of nurses into the field of public health; encourage the maintenance of NOPHN qualifications for public health nurses; and endorse the merit system.

VII. WHEREAS, the nurse in industry and her interrelation with public health nursing are constantly increasing in importance, and the present resources for her preparation are inadequate, be it

RESOLVED, that the NOPHN encourage university and college programs of study in public health nursing to give special attention to and make provision for the educational needs of industrial nurses including special courses where needed.

VIII. WHEREAS, school nursing service is an essential factor in the health of the school child, and the nursing profession is directly concerned with its sound development, be it

RESOLVED, that the NOPHN recommend to state organizations for public health nursing and to the public health nursing sections of state nurses' associations the appointment of special committees to consider problems of school nursing, such committees to comprise public health nurses and nonprofessional members of the respective organizations interested in school nursing.

IX. WHEREAS, the principle is generally accepted that good health is a right of

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Nursing in Health Service Plans

By MARIAN G. RANDALL, R.N.

THIS is a progress report on selected phases of health service plans which are of particular interest to nurses. It is a discussion of some of the recent developments in what is variously termed health insurance, medical care or prepayment plans as well as a report on some activities of several national committees. Historical developments are omitted and no brief is held for a comprehensive report of current happenings. But there is sufficient evidence to indicate that even a limited report of this kind will be of interest and it is therefore presented to serve as a basis for further discussion.

The increasing public concern in security against the burdens of medical costs is one of the most important reasons why further consideration should be given to comprehensive plans which will provide all the essential services needed to attain and maintain the desired state for all. There is also sufficient and growing interest within the ranks of the professions concerned with health to prove that the members of such groups are realistically aware of the relation of medicine to the social order in which it functions.

It must be fully recognized that there is far from an equitable distribution of medical resources in this country. The definition of medical resources and medical care should be broad enough to include services of physicians, dentists, nurses, medical social workers, nutritionists, physical and occupational therapists, and other personnel in the health field, and all diagnostic treatment and aftercare services and facilities (including hospitals) needed to restore or maintain health. The most superficial study of the facts makes it quite clear that the unsatisfactory distribution of resources and knowledge of social needs arises from economic influences.

While the general purpose of the Wagner Bill is highly commendatory, one of the defects is the omission of a facilities title to provide hospital and health center construction. Particularly in rural areas facilities are so inadequate that hospital benefits could not now be provided in many areas. Physicians and other professional personnel do not settle in these areas, and the benefits contemplated in the Bill could not be furnished.

There has been general acceptance in the public health sphere that in a democracy government must provide or assist in providing those services which the people alone or unaided cannot provide so effectively for themselves. The control of communicable disease and the provision of safe water and milk supplies are good examples. Far more difficult and equally vital problems confront us in providing adequate medical, nursing, dental and hospital care for all the people. Progress in medical science has increased the cost of services, thereby decreasing the proportion of the population who can afford to pay these costs. Hence, there is a growing interest in extending the prepayment principle to cover all hazards of illness, through either compulsory or voluntary insurance.

Governmental aid need not be a threat to the independence or initiative of the members of the health professions. If

proposed plans are unsound, the professions concerned should formulate better ones. The majority of the members of the health professions believe that some voluntary prepayment plans can and should continue to serve the greatest possible number of people. However, most of these professional groups realize that the voluntary plans alone cannot serve all the people and believe that some if not all health services should be financed through social insurance supplemented by general taxation.

From the voluntary plans can be learned some sound principles which the professions and the public (consumers) find satisfactory, and which point the way to the terms they believe should be, and in fact can demand shall be, included in governmental plans.

NATIONAL COMMITTEES FOR HEALTH SERVICE PLANS

The following are a few illustrations of the national committees which are giving serious thought to health plans:

1. The Joint Committee of the American Nurses Association and the National Organization for Public Health Nursing on Prepayment Plans for Health Services. (This was formerly the Joint Committee to Study Health Insurance and Its Implications for Nursing which made a report in October 1943 on the status of health insurance in relation to nursing.) Today the Committee uses different terminology and emphasizes the need to include nursing in prepayment health services or national health plans. It recommends that states organize similar joint committees.

2. The Subcommittee on Medical Care of the American Public Health Association Committee on Administrative Practice has nursing representation in its membership. The discussions of this group, which includes hospital administrators, health officers, public health administrators and others, illustrate the importance of the interdependence of the health professions which has long been recognized in practice and should be equally well recognized in planning and administration of all health service programs.

This APHA subcommittee is now working on a report which will outline certain principles of a national health plan. It is descriptive of their deliberations to say that the report will include such subdivisions as, Needs, Services, Financing, Administration, Physical Facilities, Training and Distribution of Personnel, Expansion of Research, as well as other topics. But no matter how comprehensive the deliberations of such a national committee, it is of even greater importance at this time that states and localities initiate studies and experiments to increase our practical experience and to determine further criteria for the practical administration of health plans.

3. The Hospital Planning Commission of the American Hospital Association is another important national committee which is mentioned here because they are including in their discussions the extension of benefits in the Blue Cross Hospitalization Plan. Nursing service is being considered and the time is here when this subject should be discussed more extensively in many localities.

There are several other national committees and undoubtedly there are many state committees considering various aspects of health service plans. There is no doubt of the increasing interest. The requests now coming to national nursing headquarters are for further examples of what is happening "elsewhere." For this reason a summary is presented here of a limited study which has been undertaken in New York City. It concerns one phase of health insurance, namely the extension of nursing service in prepayment hospital care plans.

STUDY BY ASSOCIATED HOSPITAL SERVICE

The interest within the nursing profession is illustrated by the request to

the Associated Hospital Service of New York from the 16 visiting nurse associations in Westchester County (organized in a nursing council) for assistance in planning and sponsoring a prepayment plan for visiting nurse service for Blue Cross subscribers in Westchester County. A request was also received by Associated Hospital Service of New York from the National Organization for Public Health Nursing to furnish leadership in sponsoring a demonstration of a prepayment scheme for health service which would include hospital care and medical and nursing care in both hospital and home. To this request was added the statement "if it does not prove feasible at this time to arrange for a demonstration on this broader basis, the Committee recommends that a demonstration of a partial scheme—namely, one that adds nursing service in homes to a hospital prepayment plan—be undertaken by the Associated Hospital Service as soon as possible. It is believed that such an experiment could obtain results of value which would contribute to the more comprehensive plan to be undertaken later."

Accordingly, the Associated Hospital Service agreed to sponsor a brief study which would include (1) a review of prepayment medical care organizations with special reference to nursing participation in such programs and (2) suggestions for prepayment plans for nursing particularly in relation to hospital care programs.

The report of this study will soon be presented for consideration of the Board of Directors of the organization known as United Medical Service Incorporated. This corporate group which sponsors medical and surgical care plans is affiliated with the Associated Hospital Service of New York. As in most states, the Associated Hospital Service of New York cannot legally enter into a contract for medical or nursing service, but there is legal provision for a corporation such as United Medical Service to contract for such service.

NURSING IN PREPAYMENT MEDICAL CARE ORGANIZATIONS

A summary of medical care organizations has been compiled by Margaret C. Klem for the Social Security Board of the Federal Security Agency.* It is a digest of the general characteristics of 219 prepayment medical service plans currently in operation in the United States, including industrial plans, private group clinics, consumer-sponsored plans, medical society, and governmental plans. As the author points out, "Many of the differences are inherent in the type of plan, its purpose, or the characteristics of the locality or group which it serves."

The individual plan digests include the professional personnel employed. In 55 percent of these it is indicated that graduate nurses are employed but the type of nursing service provided was not recorded. Conversation with Miss Klem reveals that the Board expects to publish additional reports soon which will include a summary of the types of nursing service provided. With her permission it can be stated here that most of the prepayment medical care organizations which employ graduate nurses provide only for nursing service in clinics. Occasionally the organizations which provide hospitalization reported that a special private duty nurse could be provided for seriously ill patients if the physician so ordered but such nursing service was seldom used. One or two organizations reported that home nursing could be provided by the local visiting nurse association, but this too was "seldom used." With the exception of three or four industries which provide company facilities and pay full or a substantial amount of the costs for all types of medical care for their employees,

*Klem, Margaret C. Prepayment Medical Care Organizations, Bureau Memorandum No. 55. Division of Health and Disability Studies, Bureau of Research and Statistics, Social Security Board, Federal Security Agency, Washington, D. C. November 1943.

it is correct to say that none of these prepayment medical care organizations include complete coverage for private duty nursing in the home and hospital, and public health nursing service in the clinic and home.

Copies of the study by Miss Klem are not available in large numbers, but single copies have been sent to most libraries. A review of the medical care organizations listed for a given state or locality would provide valuable information for further study. One or more of the medical care organizations in a locality may be interested in sponsoring an experiment which will extend the services offered to include all types of nursing service.

For several years, insurance companies have offered visiting nurse service in the home as an added or incidental benefit to industrial life insurance policyholders. For a seriously ill patient permission could be obtained for a limited amount of special private duty nursing service which is paid for by the insurance company. This latter service has decreased with the increase of hospitalization and use of the newer drugs. But the insurance company experience can be used to advantage in planning for the extension of nursing service in health insurance plans. Likewise the experience of visiting nurse associations which give paid service as well as free care should be used to advantage in predicting the amount and kinds of nursing care which will be needed in homes. Such experience is useful not only in predicting the amount of home nursing service needed, but can also be used in exercising methods of control of the use of such service.

The experience in hospitals in the use of private duty nurses may be used to advantage in predicting the amount of such service which should be provided if special nursing service is to be included in the benefits offered in a prepayment plan. The hospital records are useful for this purpose only if it is the practice to include all private duty nurse charges on the hospital bill. For example, in one hospital in New York in one year there were 6,935 patients admitted and discharged in private room accommodations. The hospital records showed that bills rendered to these patients totaled nursing charges of $571,184 including private nurse fees and their board. These figures indicate that in this one hospital in one year the charges for private duty nurses in private room accommodations average $82 per patient. The same type of information is available for semi-private and ward patients which as you would expect indicates a much lower average cost per patient for private duty nursing charges. Further study of such data from a number of hospitals in New York and elsewhere has been undertaken and will be reported upon at a later date.

ALL TYPES OF NURSING SERVICE

It is appropriate to record here an opinion concurred in by many that an experiment which would provide all types of nursing service on a prepayment plan would be more satisfactory than one which provides only one type of service. The objective should be to provide nursing service at the time when it is most needed. This requires special private nursing service in the hospital or in the home for a serious condition or illness requiring continuous nursing care and visiting nurse service in the home for a condition or illness requiring part-time skilled nursing care. Both types of nursing are essential.

One method of planning for private nurse service is the expense indemnity plan. For example a reimbursement for special nursing service of $5 for each 8-hour period could be allowed. It might be expected that subscribers would use an average of 6 such special nursing periods. Judging by the Blue Cross experience, 10 percent of the subscribers would be potential users of such special nursing service in hospitals.

Questions about more than an average

use of special nursing service because "subscribers would be entitled to it" are always asked when such a plan is presented. Obviously it would be a problem and perhaps it would be necessary to work out a plan similar to some of the well-known surgical expense indemnity plans whereby a specified sum would be allowed for special nursing service according to the diagnosis or "operation" for which the patient is admitted to a hospital. But few will deny that experience during this war has demonstrated that limited available nursing services can be used according to need. Hospitals, physicians, nurses and patients have been cooperative in carrying out a plan for the seriously ill to have special nursing service. Such methods of assigning service according to need might well be retained. When adequate amounts of private duty nursing service are available, the administration will be more difficult.

To administer an expense indemnity plan for special nursing service and to provide a degree of supervision necessary for maintaining desirable standards would require assistance and cooperation from both hospitals and visiting nurse associations. The patient should have freedom of choice of a special nurse, providing standards of education and preparation are maintained. To determine costs for a special nursing expense indemnity plan is not easy.

PREPAYMENT PLAN FOR NURSING SERVICE

Before presenting a plan, it is appropriate to report that considerable time has been devoted to discussing the general and specific implications of a prepayment plan for nursing with representatives of national, state, and local nursing organizations, and with hospital and medical groups. The principles of this plan have been approved by the Joint Committee on Prepayment Plans for Health Service.

Many contacts have been made in Westchester County since the nursing council there made the original request to Associated Hospital Service to sponsor a prepayment plan for nursing.

The 16 visiting nurse associations in Westchester County have agreed to cooperate in a plan similar to the one here proposed and believe they will be able to provide the required amount of visiting nurse service. The board of directors of each of these associations has expressed interest and willingness to review a specific agreement. The Westchester County Hospital Association and the private duty section of the Westchester County Nurses Association have also expressed definite interest and agreed to consider and cooperate in a plan when decisions have been made as to administrative details.

The following is a brief summary of a plan* for nursing which will be submitted to the boards of United Medical Service and Associated Hospital Service of New York:

1. *Contracts for nursing service* written by United Medical Service for individuals and families. Contracts to be sold only to subscribers of the Associated Hospital Service of New York (Blue Cross), and at first, only through industrial groups (probably in industries where employers will pay half the costs).

Minimum number of contracts required to start experiment—2,000 (approximately 1,000 individuals—1,000 families).

Maximum number of contracts to be sold first year (in one experiment)—5,000.

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*The details of the plan have been written down in the form of a sample contract, for the purpose of suggesting the precise terms required for a satisfactory discussion. This is available from the NOPHN, together with a short list of selected references, in mimeographed form, free to members. It is suggested to nurses that in attempting to work out ways in which nursing may be added to existing health or hospital or medical insurance plans, it is helpful to write out the first draft of the nursing plans in "the other fellow's language."

2. *Service*

a. Visiting nurse service in the home, visits of one hour, for which UMS will pay visiting nurse associations at the rate of $1.25 per visit, and

b. Special private duty nursing service in the hospital or in the home, *8-hour periods*, on an expense indemnity basis for which UMS will pay $5 for each period.

c. Nursing service given only when patient is under care and supervision of a physician.

d. Nursing service to be given by graduate professional nurses or, for selected cases, by licensed practical nurses under supervision of graduate nurses.

3. *Extent of service*

a. Twelve visits in the home by visiting nurse, and

b. Nine periods of special private duty nursing service in hospital or home.

The total maximum expense of these two services to UMS not to exceed $60 per year for each individual.

c. Alternate plan which actuaries say will reduce the premium costs. Subscribers to pay for first visit in home and for first day's special nursing service (3 periods) and after that UMS will pay the cost per visit and expense indemnity for special nursing periods quoted above, for all further nursing service necessary. The need for nursing service to be determined by the physician and by the director of nursing service in the hospital or in the visiting nurse association. This method insures against the more extensive costs of long serious illness.

The practice of limiting nursing service to need rather than mere wish of the patient has been carried out regularly in the last few years by visiting nurse associations. In the last two years hospitals have also exercised control of distribution of special private duty nursing service. It would be essential to have the policy of limitation of service well understood by all concerned and supervision of cases exercised by UMS when plan is initiated.

4. *Predicted use of service*

a. Estimated that 10 percent of subscribers will use nursing service

b. Average home visits per case, 5. This is based on experience of many visiting nurse associations and on experience of insurance companies.

c. Average special nursing periods per case, 6. This is based on

(1) experience in hospitals

(2) experience of many private duty nurses

(3) general experience of surgical cases who are sick enough the first three days to require some special nursing services but get along very well after that with general nursing care given by staff nurses in hospitals.

5. *Cost*

a. Exact premium to be determined after decision is made on type of plan.

b. It is estimated cost would be approximately

40 cents month—individual
90 cents month—family.

c. If predictions are reasonable, there would be, on basis of 5,000 contracts,

(1) population of 9,900 (AHS experience)
(2) 10 percent or 990 individuals using service
(3) expense to UMS—average of $36 per individual or approximately $35,600
(4) income to UMS—$38,000
(a) based on 2,400 individual contracts approximately $5 a year
based on 2,600 family contracts approximately $10 a year

It is recognized that no allowance is made here for cost of administration of this plan. It should also be pointed out that because the answers to the questions on cost and use of the service are un-

known at this time, an experiment is necessary. However, it seems reasonable to predict that the cost to UMS of one or two experiments of this type would not be excessive. In the light of present-day interest and planning such experiments are greatly needed.

Visiting nurse service costs. If an experiment is limited to visiting nurse service in the home, estimated costs are:

Individual	20c per month	$2.40 per year
Husband and Wife	30c per month	3.60 per year
Family	50c per month	6.00 per year

Predicted use of visiting nurse service. The minimum number of 2,000 contracts will be required to begin an experiment. According to AHS experience these will probably be distributed by type of contract as follows:

Individual 48 percent; husband and wife 16 percent; and family 36 percent.

For 2,000 contracts this will be

	No. of contracts	No. of people
Individual	960	960
Husband and wife	320 x 2	640
Family	720 x 3.3	2,376
		3,976

It is predicted that 10 to 15 percent of the people will use the service for an average of 5 visits. On the basis of 15 percent this will be 2,982 visits.

If these estimated costs and predictions are reasonably correct, UMS will pay out $3,727.50 (2,982 x $1.25) and will receive $7,776 (960 individual contracts at $2.40 = $2,304; and 320 husband and wife contracts at $3.60 = $1,152; and 720 family contracts at $6.00 = $4,320). The difference between income and payments ($4,048.50) will not meet all administrative costs. There will be some indirect costs, such as the necessary record keeping which would be included in the present organization of AHS or UMS. It would be necessary also to plan for direct costs such as the services of an experienced nurse to supervise and make the necessary professional contacts. If only one experiment is undertaken at this time, probably the part-time service of a nursing administrator would be sufficient. However, it would be advisable to plan soon for more than one experiment, to avoid having answers to administrative questions colored by the situation in any one locality.

If the predictions on cost and use are reasonably correct, the direct expense could be covered by the funds received and the indirect costs would need to be contributed in the interests of the experiment.

To initiate any plan, it will be necessary to consider such record forms as application blank for service, notice of claims, form letter to clients regarding claims, form letter to physicians regarding clients, claims, and others. To make the experiment of greatest value, the results should be carefully recorded and analyzed currently. To do this the experience and assistance of the staff of Associated Hospital Service and allied groups will be required and it will also be necessary to consult an experienced public health nurse in making these plans. Such a nurse will also be needed to carry out the necessary administrative contacts with the participating visiting nurse associations and hospitals and to assist in studying the results.

It is suggested that a small advisory committee of experienced nursing executives should be asked to review the progress of an experiment from time to time.

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The Nurse in Public Relations

By HORACE H. HUGHES

THROUGHOUT history, the Four Horsemen—War, Disease, Famine and Death—have gone hand in hand, but in *this* country and in *this* war, we have not as yet been visited by the increased ravages of disease and death from disease. Many of the old scourges of humanity are shrinking as rapidly as Alice in Wonderland when she ate the magic cake in the white rabbit's house. Yes, as a Nation we are quite well, thank you!

The best public health minds agree that we in America are collecting dividends in health just at a time when we need those dividends most. They are the result of many years of progressive, constructive public health efforts, coupled with great advances in the science of medicine, nursing, hospital management and sanitation.

The public health nurse has contributed much in building up our Nation's good health capital so that we are now reaping these important dividends. Her energy and spirit have brought health to millions and taught millions more what good health really is and how to protect it. She has worked unobtrusively and without fanfare, believing that community support and understanding will result from work well done.

She has said, "a satisfied customer is the best advertisement for my work." To a degree that is true. The most high powered public relations expert could never convince a community of the importance of a service that is not well done. But exclusive dependence on satisfied customers can lead to grave consequences in public relations and interpretation. A customer may be satisfied simply because the nurse is friendly or because she rubbed granny's back or for some other purely emotional reason, not because good service has been rendered on the basis of sound public health nursing principles. The interpretation to the friends, relatives and neighbors of such satisfied customers can be sketchy and distorted, even though friendly.

Then, too, those whom the public health nurse chiefly serves are not the real leaders of community thinking nor the moulders of public opinion. The growing and changing philosophy of public health nursing cannot well be interpreted to the community exclusively through these people.

As a practical test of how the nurse has been interpreted by so-called satisfied customers, I have been asking people in several eastern cities and suburban communities what they think about the public health nurse. An elevator operator in a large New York building said, "The public health nurse is the Henry Street nurse." So far so good. "She takes care of sick people who are too poor to go to a hospital." He knew of no difference between the nurse in the hospital and the public health nurse. He believed that the public health nurse stays on one case until the patient is well.

Does that attitude match up with what the nurse considers her primary function? Can't you see in these answers some potential causes of misunderstanding if ever that elevator operator should call for the help of the visiting nurse?

My postman in a suburban community simply answered, "The public health nurse—well, I guess she is just like any other nurse," and that is as far as he would go.

The ticket agent at a suburban railroad station replied, "The public health nurse is the county nurse. She takes kids to clinic." He could see no difference between the county nurse and any other nurse except that the county pays her. Then he added, "The public health nurse is like any other racketeer in the New Deal. We could do without a lot of those lazy, no good officeholders."

A newsboy commented succinctly, "The public health nurse is the nurse who rides around in the county car."

In another large eastern city replies were much in the same vein. A taxi driver said, "The public health nurse is the city nurse. I wouldn't have her if I was dying nor the city doctor either." A waitress in a restaurant provided the best reply when she said, "The public health nurse is a visiting nurse. She goes from home to home and takes care of people who can't go to the hospital. She taught my sister how to take care of her little boy when he was sick with rheumatic fever."

Most of those I questioned believed that the public health nurse had fewer qualifications and less education than the nurse in the hospital. Not long ago a young woman came to our office. She was considering what she wanted to do in life and thought that perhaps she would like to be a public health nurse. She said, "Of course I can't be a nurse in a hospital because I don't have enough education."

CERTAINLY these replies are not satisfactory. They are not numerous enough to represent the true state of public opinion throughout this country or even in the communities from which they were gathered, but this crude hit or miss sampling indicates to me that there is a great and dark gulf between what the community expects of the public health nurse and what the nurse considers her function in the community.

Suppose we put this lack of community understanding on a strictly cash basis. Raising money is going to be difficult in the years that are coming, much more difficult than it is now for private social and health agencies. There is going to be less money for contributions from those in the higher economic brackets. The competition for this money is going to be keener.

There will be a place in tomorrow's society for the progressive voluntary agency that meets the community needs and is understood by the people. That agency will be able to continue to finance itself from the contributions available. But what about the agency which is not understood? What about voluntary public health nursing? Will reliance upon satisfied customers or an intense publicity campaign during money-raising time, geared to emotional methods for wringing money out of dry pocketbooks, provide adequate interpretation?

This same question bears just as urgently on the public health nursing program financed from tax funds. If taxes continue to mount and people feel the pinch even more than they do today, they are going to call a halt in no uncertain terms. By then the war will be won. Hitler and Tojo will be relegated to their proper places. The boys will be home. The victory parades will be over. The flag waving will have ceased. The readjustments to a peacetime economy, with all its aches and pains, will be in full swing. The taxpayers will be mighty tired of paying a quarter of their income to Uncle Sam, their state and local tax collectors, when they want to buy a new house or a new streamlined car or a new refrigerator or a new television set. There is going to be some keen questioning of public expenditures. Those governmental functions which have not become fully

settled in the minds of taxpayers as necessary services of Government will be under heavy fire. In many local communities, they are already! What about public health nursing? Is it firmly established in the minds of taxpayers as absolutely essential for every citizen or does the community consider public health nursing as a service for people in certain economic levels?

Now I have a very high regard for the public health nurse and her contribution to the health and welfare of every citizen of our Nation, but I see a great weakness in the job she does of public interpretation and public relations. I am not advocating more newspaper stories necessarily or radio talks or more posters or bigger and better annual reports or more speeches to organized groups. Heaven forbid! We already have too much of that. I am thinking of the far more important task of interpretation that is part of the day-by-day job, of the very essence and philosophy of public health nursing.

NOT BEING a nurse myself and therefore not fully acquainted with danger signs, pitfalls and forbidden places, I am going to strike out boldly and ask some questions. They are questions which come to the mind of a public relations specialist as he looks on public health nursing today. Perhaps the nurse can answer these questions. I hope she can. If she can't, I think she should strive to find the answers quickly.

Does public health nursing as it is practiced today fill a need in the community? In business terms, is public health nursing a saleable service?

Is it possible that public health nursing, despite many expressions of professional opinion to the contrary, still operates basically in the era of the Lady Bountiful? That is true of much of the public medical and hospital care that is offered in this country today. A famous maternity clinic does not provide enough chairs and allows its patients to stand in the waiting room because, in the words of the doctor, "They don't mind it." I know why this clinic experienced a great falling off in the number of patients in these days when people have money to buy obstetric care. These mothers were never satisfied. They stood in the waiting room because they needed care and had to take the standard of care that was offered to them. There was no choice.

What about public health nursing? Is it as attractive as it might be or is it still based upon the assumption that public health nursing is provided by the better off in the community for those who are worse off? Do those who provide the money still claim the right to decide what kind of service is to be offered or do those who are served have a voice in deciding what the standard of care should be?

Does the community want something more than the public health nurse is giving it today? Does public health nursing have its ear to the ground? Does it hear and heed the rumblings and mumblings about the over-educated nurse with high-falutin ideas? Has public health nursing listened to the voice of America's workers who are sick and tired of the concept of charity? Does public health nursing think that it can know what the community wants if the people whom it serves are not represented on its board of directors and in its planning committees?

Is the recent decline in the number of patients served by public health nursing partly due to the fact that the standard of nursing has not met with the approval of the community? I have talked with nurses and have read their reasons for this decline. It seems that the nurses themselves attribute it to the fact that more people have more money to buy care today and are therefore less inclined to call the nurse. Does that attitude indicate a lack of satisfaction or a lack of understanding of the function of the

public health nurse? I should say that never has this Nation been more *health* conscious than it is today. But is it not true that when people think of public health nursing, they think only in terms of sickness care? Is it possible that to these people the sickness service rendered by the public health nurse is not as satisfying as hospital care? Is it possible that public *health* nursing is really public sickness nursing? Is it possible that the public has learned to call the nurse only for sickness but has not learned to call her if a dose of health instruction is needed?

THE PUBLIC health nurse has wisely used the individual's need for sickness care to gain entrance into the family. She has told well the story of health to the sick, but I don't think that she has found a way of teaching the well to stay well except in a few outstanding instances where she has done an excellent piece of work. The nurse has successfully taught the expectant mother how to stay well and she has taught the mother of a newborn baby how to keep her well baby well. That success is paying dividends in marked reductions in maternal and infant mortality.

In all fairness it must be said that the nurse is not the only practitioner who has not yet learned how to teach positive health. Our whole medical system is based upon sickness and cure. Here is a woman who feels ill. She goes to her doctor. She is examined carefully and told that she must undergo an expensive operation. When it is all over she feels much better and she willingly liquidates her savings to pay the doctor and the hospital bills for this high grade of sickness care. But suppose she goes to the doctor, and the complete and thorough examination, requiring the utmost knowledge in modern medical care, reveals that nothing of importance is wrong. Some minor adjustments in her diet and her living habits put her back on the road to health. She dislikes paying that bill. She feels somehow that she didn't get her money's worth.

This human attitude is undoubtedly the greatest obstacle which the nurse and the doctor and the health educator have to meet. But none of them have really as yet met this obstacle with acumen. The nurse, the doctor, the health educator, must learn to put the emphasis upon health and prevention, upon the positive side, not upon sickness and cure.

The very language of nursing needs to be changed if this positive concept is to be forcefully brought home to the public. The nurse speaks of her "*patients*." In the annual reports of nursing associations, the statistics indicate that so many "*patients*" have been served. What is a "*patient*"? According to the dictionary definition, a patient is "a sufferer, one who bears or endures—a sick person." The nurse's whole vocabulary should be thought through in relation to this suggestion. It may seem to be picayune and hair-splitting, but the basic philosophy of the nurse can be misinterpreted by the words she uses.

It seems to me that the whole future of public *health* nursing depends upon the success of positive teaching. Otherwise, if and when public funds are available for medical and nursing sickness care, the public may choose hospital care and the public health nurse may be out in the cold. What then? The public health nurse has a great contribution to make in the field of prevention, which to me is the coming important phase of public health. But if she is to be useful, this function of teaching and of prevention must be understood by the community.

Has the public health nurse carefully thought through the forces that are at work in our society and does she know how they may affect her and the job she does? Does she fully understand that sudden shifts of public opinion in regard to the basis of medical, nursing and hospital care can change the whole course of

her profession and remove the control entirely from her hands? Does she realize that the function of public health nursing in the days that are coming may be decided by others because she has continued to do a good everyday job for the patients who come to her and depended upon satisfied customers to interpret her work? Has public health nursing come to realistic grips with the great readjustments in our postwar society? What about the growing field of industrial medicine? What about the homecoming of nurses from the armed forces and the cadet nurses who will soon be graduating in large numbers? Are places being made for them in the economy of public health nursing? What about the millions of our people who are not getting good public health nursing service today? Is public health nursing really concerned about this problem? Has it brought that concern to the attention of the public?

Nursing was dynamic at its inception. Florence Nightingale did much more at Scutari than to care for dying soldiers. She convinced the British War Office, and later Britain and the world, of the vital importance of the nurse. She had a keen sense of public relations and she interpreted nursing so successfully that it developed into a profession as the result of her efforts. She was vocal, dynamic and fearless. The job has been done so well that today the armed services requisition nurses from home front duty in such large numbers that the whole structure of civilian nursing care is gravely threatened. Has nursing become timid today?

NO ONE is closer to the life of the community than the public health nurse. She sees the coming of life, the problems of life, the happiness of life, the disaster of sickness, the coming of death. She sees the relationship of families to medical care, to schools, to business and industry. But I have yet to hear public health nursing speak out with a strong voice against the unmet nursing needs or for better organized or more complete nursing care, in a logical and orderly fashion. My frequent talks with nurses do not indicate a sufficient unity of thinking or a willingness to speak out strongly and courageously. If nurses are thinking through these problems, and I am sure they must be, they should remember that you can't deal with public problems in private. You can't carry the Chamberlain umbrella of unwillingness to take a stand and not suffer the consequences in bad public relations. If you are not a leader, you are destined to be a follower. I suppose some of this unwillingness to speak out comes from the drilling which the nurse receives in her early training. The nurse has learned to say "yes, doctor" or "no, doctor" in unthinking, military fashion. It is not mine to question the rightness of that kind of training, but I do question the subservient attitude toward affairs which affect the whole profession of nursing and its relationship to nursing and other services in the community. If public health nursing is a profession, and certainly I believe that it is, then that profession should think for itself and learn to speak for itself. It should not depend upon other professional groups for its cues.

I am very sympathetic with the problem of the individual nurse. Her whole future, the future of her job, may be jeopardized by speaking out as an individual. Perhaps sometimes she should have courage to do so, but the nurse doesn't need to speak out as an individual. She should learn, as other professions have learned, to speak out collectively. The technique of speaking out collectively avoids the pitfalls of individual speaking. An illustration of how laxity in collectively speaking out has harmed the whole profession is clear in the answers I received to my questions about public health nursing. Most people believed that the qualifications for public health nurses were lower than for

hospital nurses. Then there is this subject of salaries, which in the last analysis is a public relations problem. I don't need to remind you that the nurse's salary in many cases is nearly as low as the day laborer's. That is so because the public health nursing profession has not interpreted the nurse and her job and the importance of her job to the community.

There is another aspect of speaking out at which some public health nurses have been more adept. They have learned how to enlist others to speak out for them. In some communities committees of citizens have been of great assistance in many practical ways to the nursing program. They have helped the nurse in the daily performance of her job and thus have come to understand the philosophy of public health nursing. They have gone to bat for her before appropriations committees. They have interpreted her to the organized groups of the community. I know of one nursing program that was saved a grave reduction of service by the quick and effective action of a well-informed committee of citizens. More nurses must learn how to teach others to do the talking and to organize the community for effective action. People are accustomed to serving as volunteers during wartime. If their interest and ability can be enlisted during the uneasy days following the war, nurses will have a new corps of interpreters, ready-made and willing. The iron is hot —strike it!

POSTWAR America needs the public health nurse. Men and women in the armed forces have been seeing the world, participating in great historic events, living under intense excitement. Families have been broken up—some never to be reconstituted, children have been insecure, medical care has been delayed. This overstimulation, this insecurity, this readjustment of families to peacetime living create family problems of the utmost complexity. All our community facilities for health and welfare will be taxed to the utmost. The public health nurse, with her knowledge of people, with her knowledge of community resources, with her knowledge of how to teach, can play an important role in the reconstruction.

To do her job well, however, she needs the sympathetic understanding and financial support of the community. At this critical time, she must not be on the defensive—explaining here, apologizing there, begging for money from a quizzical public. She must be a leader in the coming reconstruction, with a voice of her own, and a power of her own. Her task is part of the Herculean work our Nation has before it, capably summed up by Abraham Lincoln who said at a similar time in history just before the close of the Civil War, "Let us strive on to finish the work we are in; to bind up the Nation's wounds; to care for him who shall have borne the battle, and for his widow and his orphan—to do all which may achieve and cherish a just and lasting peace among ourselves and with all nations."

To play her part in this task, the public health nurse today must do everything in her power to interpret the job she is doing to the community and to the Nation.

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Recent Developments in Treatment of Syphilis in Relation to Patient Education

I. The General Perspective

By JOHN H. STOKES, M.D.

THESE are great days in venereal disease control. The observer, particularly the old guardsman, finds himself whirled along in his venereologic jeep over the road to somewhere at a pace which makes it difficult for him to tell whether he is moving past the landmarks, or the landmarks are moving, leaving him standing. The essential changes, actual and impending, are these: the whole dose of an effective arsenical (mapharsen), 20 to 30 milligrams per kilogram body weight, can be given to a syphilitic patient with curative effect, in 85 plus percent of cases in a period ranging between 5 days and any number of weeks or months up to the established 60 or 65. The faster the treatment is given, the greater the danger to the patient. No substantial advantage has yet been demonstrated in the curability of the disease as such by the increased rapidity and concentration of the treatment. It is clear that the addition of bismuth to this intensive type of arsenotherapy greatly increases the proportion of good results. The old rule is that the earlier in the course of the disease (namely seronegative primary syphilis as the ideal) the treatment is begun, the higher is the proportion of cures. Indeed it can be made to approximate 100 percent in the seronegative primary case group.

Simultaneously with the unavoidably increased emphasis on the toxicity of the arsenicals when intensively used, there is developing a technic of arsenical detoxification, which probably will not be made fully available to the medical public before the close of the war. Its applications and limitations are still under study. It is not unreasonable to suppose that ultra-intensive treatment with the arsenicals, including the 5-day intravenous drip, the 10-day multiple injection technic, the 10- to 12-week Eagle-Hogan technic, with 3 injections a week plus bismuth, can all be reduced to a common level of comparative safety, comparable to that of the old standard methods by the immediate availability and use of detoxifying agents at the moment that the first warning of a complication appears.

In one stroke then we see the reduction of the time-stymie in syphilis treatment, and the danger of toxic reaction, to all but negligible proportion.

To be sure, these gains are not without their costs. Hospitalization, the necessity for the administration of treatment under expert direction, are prerequisites calling for organization and centralization of the treatment of venereal disease, and syphilis in particular, in the hands of special centers. Such centers are in process of establishment on a large scale (Rapid Treatment Centers) under

the auspices of the United States Public Health Service cooperating with the state departments of health. A number of the larger cities, with Chicago in the lead, have established centers on their own account or with government assistance.

I here give only passing mention to what appeared for a time to be the most eligible solution of the syphilis treatment problem available, namely, the simultaneous use of fever and chemotherapy. Fever and chemotherapy combined have not established themselves as materially more efficient than the intensive chemotherapy as such. And the increased expense, centralization, technical skill, and risk from hyperpyrexia as such, involved in such methods, would probably make them lose ground as arsenical detoxification reduced the risks of maximum dosage chemotherapy to a minimum.

"BEHOLD, I tell you a mystery. This shall all be changed, in a moment, in the twinkling of an eye." You know, of course, that I mean penicillin. On the basis of published material available to this date, there is strong reason to believe that penicillin will provide a short, safe method for the effective treatment of early syphilis, which will, as the biologic agent becomes sufficiently available, do away with the dangers of intensive arsenotherapy while preserving the time-saving values; do away with the need for expertness and centralization of treatment facilities; and will, in addition, combine under one single therapeutic agent and in one single method, the treatment of the two principal venereal diseases, gonorrhea and syphilis. Up go all the treatment centers, up go all the hotboxes, out go the beard-wagging syphilologic experts, out go the tricky sulfonamides, and in once more comes the general practitioner and his needle-wielding office assistant or nurse. Of course, it is not all quite as simple as that. The cup of experience still has a slippery lip, but if penicillin makes good on its promise to date (and there are substantial "ifs" yet to be evaluated), the cure of gonorrhea and syphilis simultaneously or individually acquired can be made, as a wag remarked, "cheaper than acquiring the disease."

Where is the patient in this cloud of dust in which the most experienced of us can hardly do more than clutch his cloak and exclaim, "Here she comes—there she goes. . . ."

THE FIRST THING to impress old stagers in the field is, strange to say, not so much the changes in the stuff we work with as the new technic of publicity. Before he has heard of penicillin, more than one doctor will have a clipping from *Time* or his daily paper thrust under his nose by new or old patients. A marked copy of *The Reader's Digest* will be sent him by special delivery mail. He will find himself discussing the pros and cons of treatment effects for which he has not even dependable textbook reference, to say nothing of adequate medical journal citations, with patients who have received their gospel line from newspaper feature writers received into inner sancta (we assume) before anything appeared in the scientific prints. In the welter of hearsay, it will be more difficult to present in their true perspective the treatment and recovery problems of many individual patients. So long as the intensive arsenical systems manage to hold their ground (and may that time be short), it will be necessary not only to explain to the patient the relative grades of risk involved in their relation to the end to be attained, but to secure medico-legal releases (for what little they may be worth) on the use of the more dangerous methods, and incidentally to convince the patient that 10 hours in the hotbox with a needle in his arm is not available, and why not, and why perhaps he should not have it if it were. Increasing difficulty

will be experienced as the treatment becomes simpler and simpler and less and less impressive in accomplishing that most fundamental thing in the control of the patient with a venereal disease—an education in social responsibility. If there was any one thing that the 65 weeks of the old system did for the patient as a human being, it was to educate or re-educate him to responsibility for health and sound human relations. What the patient who in 8 days steps out of the penicillin clockwise merry-go-round has really acquired is an increment of irresponsibility and an impress of the casualness and insignificance of his infection rather than its importance and the necessity for a painstaking and prolonged cooperation. If penicillin brings us the longed-for 100 percent invariable cure, thus abolishing the reservoir of relapse, such considerations may perhaps lose a part of their importance, but re-infection and exposure thereto will grow rather than diminish as hazards under the simplified and safetified treatment procedures. It is even conceivable that, as Pelouze has predicted for gonorrhea, suppression of infection rather than cure in an as yet unknown and not necessarily very large proportion of treated cases may, when combined with this attitude of irresponsibility and casualness, furnish the basis for epidemic spread through re-exposure and re-infection from a comparatively small reservoir of uncured disease.

IT IS, therefore, not a matter for unqualified congratulatory acceptance that the newer methods of the treatment of syphilis and of syphilis and gonorrhea shall have been elevated to a positive pleasure, as has been reported in the mental attitude of Neisserian vacationists enjoying a few days or weeks of off-duty status as a reward for acquiring a venereal disease. The necessity for health education, undertaken with the individual patient before one, will become more, not less, acute. Scattered out all over the lot, acquired by everyone and treated by everyone everywhere, the venereal problem will be diffused throughout the community in a fashion that will tax the resources of organized public health to the limit. A moral element will inevitably enter the picture. The teacher of health procedure will, we hope, find it difficult to resist the impulse to lay hands upon the moral and general social and educational aspects of the venereal disease control problem. Instead of being concentrated in the individual interviewing cubicles and consultation rooms of clinics, the control of venereal disease will be distributed through innumerable private medical offices with corresponding accentuation of the problems of contact tracing, to say nothing of case holding. When one considers that a large part of the danger inherent in the infectious case from the standpoint of contact transmission is antecedent to and not following the first treatment, and that infectious relapse in the supposedly cured but not followed patient is an undefined but real danger, the seriousness of this cut-down in time available for the development of rapport between worker and patient from five or six weeks to five or six days, will be apparent. As arsenotherapy with detoxification and the hotbox go into the discard, as they well may, the problems of epidemic spread of venereal disease in the pre-treatment exposure period, lacking efficient rapport between contact-tracer and patient, may well rise to the proportions of an overwhelming menace. All the resources of public health organizations, formal education, and the morale-building and delinquency control organizations may find themselves overtaxed, if not actually unable to meet it.

It must be clear, therefore, that the fighting front of venereal disease control is shifting—it has not gone out of existence with the advent of superior weapons of attack and defense. The control prob-

lem is still a human one; the time element works against as well as for; the cheapening, the safety, the facilitation in disease control, can directly expand instead of shrinking the volume of disease to be dealt with. The worker who lies back upon his oars at this juncture, believing the finish line crossed and the goal attained, may be venereal disease control's worst enemy by default.

II. The Specific Application

By ALICE M. KRESGE and DOROTHY H. BRUBAKER

ON "the fighting front of venereal disease control" referred to by Dr. Stokes, there are representatives of various professional groups: physicians, technicians, nurses, social workers, and educators. We are discussing here the contribution of the public health nurse not only in the syphilis clinic but in the public health nursing agency. The medical social worker has participated in the presentation of the problems of the patient who is on intensive treatment schedules because both social worker and public health nurse in the clinic have been in a position to study these problems and to work out plans for helping the patient to meet them. The division of responsibility between medical social worker and public health nurse has been discussed previously.*

The public health nurse continues to have an important contribution to make to the field of venereal disease control if she is interested in keeping abreast of the rapidly changing methods of treatment and care of the patient and if she actively concerns herself with the problems presented. Changes in the field of treatment make it even more necessary for the patient to have intelligent help and understanding. Rapid, foreshortened courses of therapy are not the whole answer to the control of syphilis. At least temporarily, the problems syphilis creates for the patient are increased rather than decreased.

The factors which have long been recognized as influencing a patient's securing treatment for syphilis are still in evidence. These factors are the patient's understanding and acceptance of the diagnosis, his understanding of the treatment he is to receive, the skill involved in the administration of the drugs, the availability of clinic facilities including a wide range of clinic hours, the cost of medical care, the patient's ability to take responsibility for treatment, his working hours, his efforts to prevent others from learning of his diagnosis, his fears for himself and his fear lest he infect others. The importance of these factors is not decreased by the type or length of treatment. The patient has additional problems incident to the requirements of the foreshortened schedule involving time, cost and lack of acceptance of the new treatment due to incomplete evaluation of its efficiency.

Even before the revision of treatment plan doubled or tripled the number of weekly clinic visits or necessitated hospitalization, patients had been faced with increasing difficulty in arranging for clinic care. Working hours increased, overtime work which could not always be anticipated in advance became more general and there were many industrial plants

*Kresge, Alice M., and Brubaker, Dorothy H. "Public Health Nurse and Social Worker in a Venereal Disease Program." PUBLIC HEALTH NURSING, June 1944, p. 269.

where employees were expected to work alternating shifts. It was no longer possible because of efforts to combat absenteeism to arrange with the foreman for time off to keep clinic appointments since any tardiness or absence demanded a more formal arrangement. The treatment demand which increased at the same time that there was a "tightening up" generally by employers has resulted in increased difficulty for the patient. Again and again patients welcome the possibility of intensive treatment only to be confronted with the impracticability of fitting the treatment plan into their weekly work schedule. It is seen that one of the greatest problems for the patient is the organization of his time to permit following the intensive treatment schedule. This is true for the employed individual, and it is also true for the unemployed person who is not accustomed to organizing his time.

HOSPITALIZATION is required for certain types of treatment and this may not be acceptable because of the threat to employment. The objection to hospitalization by patients is largely on the basis of the difficulty in withholding the diagnosis from family, friends and employer. The advantage of hospitalization is that chemotherapy is insured regardless of the responsibility of the patient. If the patient is not hospitalized and is required to report three times a week for treatment, the clinic must make treatment available to him at regular and frequent intervals during the week. It is important that evening clinic hours be offered. Obviously it is impossible for a clinic with two sessions a week to offer a treatment schedule requiring attendance three times a week. The choice for the patient is further limited since even if a clinic is in session six days a week the patient is required to space his treatment on a fixed schedule, such as Monday, Wednesday and Friday, or Tuesday, Thursday and Saturday, to insure regularity of medication. If there are only two evening sessions, as in our clinic, it is necessary to arrange for the third treatment. However, since it may be difficult for the patient to take time off from work and although he may prefer to pay a private physician's fee for the third treatment, only a few patients are able to bear this additional expense. One patient who started on treatment three times a week when working five days a week had planned to get treatment at Tuesday and Thursday evening clinics and on Saturday morning. When it became necessary for her to work full time on Saturday she felt the only solution was for her to get the Saturday treatment from a private physician. It cost her what she earned in the extra day to pay for the single treatment, but she felt this to be preferable to endangering her position by having her employer question why she could not work on Saturday.

The cost of hospitalization if it has to be borne by the patient may be a serious problem, since it involves not only the expense of medical care but also the loss of income during this time. If there are dependents, careful planning is necessary. While insurance for hospitalization may pay benefits regardless of the diagnosis, many health insurance policies, on the other hand, pay no benefits if there is a diagnosis of a venereal disease.

THE COST to the patient must receive consideration in the evaluation of whether he can meet the demands of the foreshortened treatment schedule. The total cost of treatment given three times a week is no greater than that given once a week, but the weekly cost is three times as great. Although current wages in defense industry have raised the income level of the outpatient group, it cannot be assumed that the rise is sufficient to enable any individual patient to meet this tripled expense even for a relatively short

period of time. This necessitates that provision be made for adjustment of clinic fee. Since it is desirable that visits for observation be emphasized, it is necessary to provide flexibility in the matter of fee so as to permit adjustment to the need of the patient. It is generally unsettled whether it is desirable that a patient pay for these visits, but if omission of the fee is a factor in insuring the return of some patients, it has the disadvantage of minimizing in the patient's mind the importance of these visits following therapy, and this is to be avoided.

One of the most serious problems for the patient treated with shortened treatment schedules, and one of which he is unaware, is the lack of acceptance of the newer drugs or rapid treatment schedule outside the syphilis clinic. There is bound to be a time lag before the various types of rapid treatment have received the evaluation which will make acceptance universal, but in the meantime the problem this creates is a real one for the patient and a potential threat to his employment. Educational efforts have been devoted to the recognition by lay organizations that a patient who is under treatment is non-infectious and is employable. Industry has progressed in its thinking to the point of being willing to employ individuals with syphilis, but all too frequently it is with the provision that the employee continue to report for weekly treatment, and many industrial concerns require that the patient present a written statement that the weekly treatment has been received. They have not yet accepted the adequacy of foreshortened therapy. Even on the Civil Service medical questionnaire a history of syphilis is a barrier to consideration unless the individual has received the recognized standard type of treatment regardless of expert medical opinion as to the efficacy of intensive treatment.

The following case illustrates these difficulties: A 21-year-old typist insists that if she ever has an opportunity to give advice to a prospective patient she will, from the benefit of her own experience, caution against any but standard treatment. She has completed intensive therapy to the satisfaction of the medical staff, but she is bitter because of employment opportunities that have been closed to her—not because she gives a history of having had syphilis, but because having had syphilis she has not had treatment that is acceptable. Another patient who had had intensive therapy but remained sero-positive returned and begged to be started on standard treatment. These are exceptions, but they call attention to the problems confronting patients.

These inconveniences to the patient must receive consideration and an opportunity is offered in the interpretive interview for the patient to discuss his problems and work out a plan to meet them. The interview is seen as a method of health teaching. Social factors may handicap the patient in accepting and planning treatment and may necessitate social study and treatment which would be the responsibility of the medical social worker.

THE AIMS of the interpretive interview—case finding, case holding, control of infectiousness, education of the patient—remain the same for the patient on standard or intensive methods of treatment. While some shifts of emphasis in relation to these aims may be necessary, the established principles of case finding, for instance, remain unchanged. The patient must still understand the need for examination of his contacts—those individuals exposed to syphilis within the time period during which the disease is transmissible. He must understand why the clinic worker asks for the names of contacts. He must know what use will be made of this information. If he cannot or does not wish to assume the responsibility for examination of his contacts, he

must understand how the exposed individual will be approached by the epidemiologist.

The patient must be told how to observe infectious precautions. Here again there is little change in the interview. The patient treated with intensive therapy observes the same infectious precautions as does he with early syphilis who is being treated with the 18-month schedule. However, with intensive therapy he may be rendered non-infectious in a shorter period of time. He must discuss with the physician when sexual intercourse may be resumed, plans for marriage, et cetera.

The changes in the content of the interview and the shifts in emphasis take place chiefly in the area of case holding. The tendency is to think of treatment merely as the administration of drugs and to consider the period of observation, or follow-up, as a separate but related entity. Actually, treatment might be more properly regarded as the whole medical management of the disease—medication and observation. Accordingly we believe the treatment problem should be presented to the patient in terms of the total period of medical management of his syphilis, not merely as a matter of days or weeks of drug administration. Presentation of the equal importance of medicament and observation would be helpful to the person who, on completion of actual drug administration, believes that he is through and who regards with impatience the need for check-up and the necessary continuous pressure used to urge his periodic return to the clinic.

It has been our experience that patients who have completed intensive treatment schedules find reporting at intervals of one month more difficult than had been the actual reporting for treatment at frequent regular intervals during the same week. Since the patient has carried through a difficult and demanding course of treatment to what he feels to be a successful conclusion, it is probable that a period of reaction occurs. This makes it all the more important to present treatment to him at the outset not only in terms of administration of drugs but in terms of necessary post-treatment medical observation as well. The physician initiates this thinking and it is then reinforced by the clinic interviewer. It requires more emphasis than does the similar point of prolonged observation for the patient on standard weekly treatment. The patient on intensive therapy must think in terms of long-time medical observation as does the patient on the old treatment schedule.

Our clinic's use of several treatment schedules has a distinct value for the patient in that it gives him an opportunity to accept a scheme of treatment best suited to his physical and economic circumstances. Actually he cannot choose treatment as such, but he is allowed a certain freedom in the selection of a treatment schedule to which he believes he can adhere. Because he participates in planning treatment to meet his needs, he works on something which he himself wants and sees as possible. It is not a treatment schedule arbitrarily imposed upon him as was necessarily the case when the clinic offered a single routine treatment.

THE INCREASED importance of medical observation for the patient on intensive therapy and the element of choice involved when the patient may receive therapy during hospitalization or during frequent clinic visits over a comparatively short time are two important items necessitating changes in the interview. In foreshortened treatment the total amount of arsenicals given is not much changed. Only the time period during which they are administered is changed. Patients raise questions about this. It is important that the patient realize the increased dangers due to toxicity which are an ac-

companiment of shortened intensive courses of treatment. He must know how to get in touch with a clinic physician whenever the need arises. It must be emphasized that he should report to the doctor at once if he has any headache, nausea, fever, itching or skin eruption. Although the increased dangers inherent in foreshortened intensive treatment should be made clear, it must be emphasized that these dangers can be reduced if the patient seeks prompt medical attention at the first sign of reaction.

The somewhat drastic nature of intensive treatment requires more than ever that the patient keep himself in the best physical condition possible. A balanced adequate diet is stressed. Adequate rest takes on additional importance. The avoidance of alcoholic beverages is desirable because of their possibly inhibiting effect upon the action of the drugs. If nothing else, alcohol may interfere with the patient's desire to report regularly for treatment.

SUMMARY

The areas in which the public health nurse contributes to the control of syphilis remain little changed. In some respects, she has a more clearly defined opportunity to serve the patient. If, as a clinic nurse, she gives treatment herself, perfection in technique of intravenous and intramuscular administration of drugs is especially necessary when the patient is receiving treatment three times a week or several times a day. Inexpert administration of the drugs used may make it impossible for the patient to present himself at the frequent and regular intervals necessary for adequate treatment.

The public health nurse in the clinic can use the interpretive interview to an even greater advantage when the patient is to receive foreshortened treatment for syphilis. The broad content of the interview is the same, but new factors about treatment are introduced and old points require additional emphasis. Many patients choose short courses of treatment because they feel that in doing so they choose something which is quickly over and done with. The nurse helps the patient to look realistically at the treatment offered him by the clinic and to choose that schedule which he feels he can carry through successfully by attending clinic regularly and without interruption. She helps the patient to understand that adequate treatment means a period during which drugs are administered and also a period during which he must report for examination and blood tests.

Changing methods of treatment do not alter the public health nurse's concern for family health. Family investigation when one member of the group is found to have syphilis is still necessary. The teaching of infectious precautions when this is indicated for the patient with early syphilis continues to be the nurse's responsibility. Medical supervision early in pregnancy for every antepartum patient is no less important. The nurse continues this teaching through her nursing services to families. She may be giving bedside care in the home to a patient incapacitated because of a complication of late syphilis. She may be giving health supervision in a maternity, school, or industrial health program. She may be an epidemiologist in a program for venereal disease control. Whatever her responsibilities, it is imperative that she be well informed on changes taking place in methods of treatment. It is only through an understanding of what is involved for the patient that the public health nurse can give him the assistance needed, and so render service both to the individual and to the community.

The mother assists the visiting nurse in the first demonstration of the application of hot packs at home, using an electric washing machine and wringer

Meeting an Epidemic of Infantile Paralysis

By CORALYNN A. DAVIS, R.N.

DURING the 1943 poliomyelitis epidemic in Chicago, the orthopedic nurses of the Visiting Nurse Association visited the homes of more than one thousand patients afflicted with the disease. Six hundred and twenty-seven patients received treatments at regular intervals in their homes, 209 patients were treated during the quarantine period. A total of 11,791 treatments were given by our nurses during 1943, of which 1,116 were given during the acute stage.

The first cases of poliomyelitis reported by the Health Department of Chicago in 1943 were located in sections of the west side of the city. As these patients returned home and were referred to the VNA for aftercare in their homes, the case load in this epidemic area was increased with great rapidity. The services of several nurses were concentrated in this part of the city. Gradually there was a spread of the disease throughout the whole city.

By the middle of August, the nurses found that many of the patients reported by the Health Department were quarantined at home because the communicable disease hospitals and isolation units in private hospitals were not able to care for the rapidly increasing number of cases. Our care in the home was at once extended to the patients quarantined in their own homes as well as to those patients who returned home daily from the communicable disease hospitals and other hospitals and required convalescent care and treatment.

The physicians and families were

greatly relieved to know that adequate home care was available. On several occasions, the nurses found that patients quarantined at home with what seemed to be a mild form of poliomyelitis had suddenly developed bulbar symptoms or indications that the muscles of respiration were seriously affected. While arrangements for hospitalization were being made, the nurses remained in these homes far into the night to carry out the orders of the physician to relieve these progressive symptoms, until an ambulance arrived to take the patient to the hospital.

The time spent by the nurse in giving the first treatment in the home was usually more than two hours. If the patient was quarantined at home, the mother or some responsible member of the family who was to give care to the patient was instructed in communicable disease technique. The services of the father, an interested relative, or neighbor were enlisted to raise the patient's bed to a convenient level, to place boards between the springs and the mattress to make the bed firm, and to construct a foot rest. While this was being done, the nurse demonstrated to the mother the bedside nursing care of the patient, the handling of the patient to avoid pain or discomfort. When hot packs were ordered, the equipment in the home was used and supplemented as needed. Electric washing machines were often brought up from the basement or hand wringers supplied by neighbors or friends were installed in a convenient spot so that the packs could be wrung out and applied with comparative ease. The wool was cut in the proper shapes and the rubber sheeting also fitted to suit the needs of each patient. A demonstration of the application of packs was given on this visit.

The demand for wringers, woolen blankets, and rubberized sheeting materials often exceeded the supply. From various sources these requests were

An older daughter or other family member often learns to apply packs as deftly as the mother

An electric "doughnut heater" is used to boil water and keep it boiling during pack application

Or the wringer can be attached to pail or metal container in which packs are then boiled on top the stove. Both wringer and pail are brought to the bedside for application of the packs to the patient

promptly filled. Gifts of woolen blankets and blanket material from the directors of the VNA and from the Cook County Chapter of the National Foundation for Infantile Paralysis, as well as wringers, scultetus binders, rubber sheeting and other essential supplies from friends of the VNA made it possible for the needs of every patient to be adequately met.

The interest and enthusiasm which the mothers have manifested in applying the hot packs have made it possible for the nurse to allow the mother to assume this part of the treatment after a demonstration by the nurse and a return demonstration by the mother on the subsequent visit. Many families worked out devices to make the treatment more convenient and easier for the one applying the hot packs.

This stand to hold pail of boiling hot packs, wringer, and surplus water pail was built by the father

In each home the mother was assisted in planning her work so that the packs and care of the patient would be done systematically. Written instructions were left in the home to make the care of the patient easily understood.

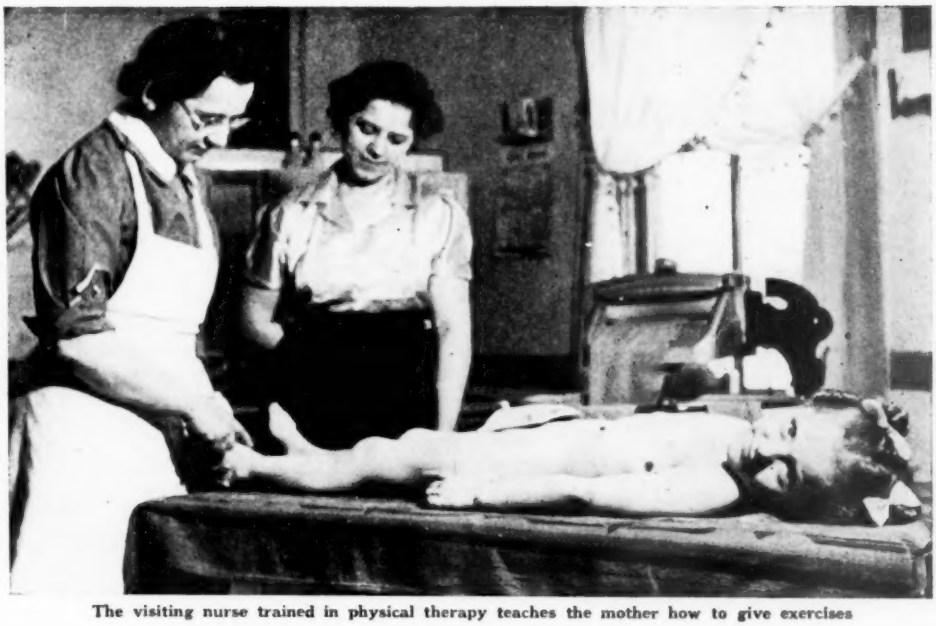
On the door of Ralph's home, the nurse found at the time of her second visit a hand-printed card which read:

DO NOT RING THE BELL FOR 20 MINUTES AFTER THE HOURS

8 A.M.	2 P.M.
10 A.M.	4 P.M.
12 NOON	6 P.M.

AS HOT PACKS ARE BEING APPLIED DURING THESE INTERVALS

As the number of patients to be treated in the homes increased, the nurses learned to plan the work in the home more efficiently. The family assumed more responsibility in the care of the patient and many parents were taught to give passive movements at first, and later



The visiting nurse trained in physical therapy teaches the mother how to give exercises

some of the active exercises. In each case the mother demonstrated that she could give the exercises as shown.

Many patients showed steady and rapid improvement and eventually were able to return to school and normal activity. Monthly visits were made to be sure that tightness and weakness did not return with increased activity and parents were instructed to watch for signs and symptoms of overactivity and tendency to poor posture and to have frequent check up by physicians.

Patients with more weakness have longer periods of convalescence and are taught to take their first steps in walkers, on crutches, or with the use of braces and crutches. Some of these patients have been interested in work with their hands such as occupational therapy and helping with household tasks to make the period of illness less tedious. Others have been able to go to special schools and continue their studies which were interrupted.

During the past few months, patients who have been hospitalized for long periods have returned to their homes for further treatment. These patients are also taught to walk with apparatus and have to be adjusted to their home surroundings again. Families of these patients are also taught to give treatment.

Ten of the nurses on the staff of the Visiting Nurse Association are physical therapists, five have been trained in orthopedic nursing while working on the staff, four of these during the recent epidemic. The combined efforts of this group of nurses working faithfully and loyally together have made it possible to give adequate treatment to this large number of patients, many of whom will require treatment and instruction for many months to come.

SEE ANNOUNCEMENT OF ORTHOPEDIC SCHOLARSHIPS, PAGE 381, AND ALSO LIST OF ORTHOPEDIC MATERIAL AVAILABLE FROM NFIP, JUNE ISSUE, PAGE 303

Public Health Nursing in the 1943 Polio Epidemic

By JESSIE L. STEVENSON, R.N.

A REVIEW of services given by public health nurses in areas where epidemics of infantile paralysis occurred in 1943 may help nursing agencies in other communities to understand the problems presented and to plan for similar outbreaks. Public health nurses gave and taught nursing care both in the hospital and in the home, assisted in bringing potential cases to early medical attention, and took an active part in teaching newer technics of treatment.

SHARING OF PERSONNEL

Many examples have been reported concerning ways in which community agencies worked together to meet the nursing needs of the emergency.

In Oklahoma the State Department of Public Health sent one nurse from each local health department to spend 5 or 6 days on the hospital wards. This plan not only supplemented hospital service but prepared one public health nurse in each locality to teach the mother when the patient was discharged. A total of 25 nurses spent 119 working days on the wards.

State agencies in Colorado, Texas, and Rhode Island, and visiting nurse associations and city health departments in Denver, New Haven, and Detroit reported similar planning. Public health nurses also did volunteer service in hospitals in addition to their regular work. The VNA of New Haven, Connecticut, reports:

> As the pressure on the hospital staff became more acute, many of our nurses volunteered to give late afternoon or evening time (after working hours) to assist with feeding of infants or crippled children, give evening care, and meet other needs. One nurse gave 7 mornings of her vacation time. In all, 33 nurses worked well over 500 hours in the hospital. Nurses who did not feel that they could go to the hospital because they had small children tried to relieve their associates of extra assignments, as Sunday duty, during this period. One of our older supervisors assisted in the out-patient department 3 mornings a week for a month in order to release a staff nurse for assignment to the isolation ward.

The use of physical therapy in the acute stage of infantile paralysis has created a new problem in isolation hospitals since physical therapists are usually not employed on the staffs of these institutions. To make this important service available, these workers had to be borrowed from other agencies in the community or elsewhere. In Detroit, the Visiting Nurse Association loaned 2 public health nurse physical therapists to the Herman Kiefer Hospital for 2 months.

Another illustration of effective utilization of trained personnel was reported in Rhode Island where approximately 160 patients were hospitalized in the Charles V. Chapin Hospital in Providence during the epidemic. The Providence DNA, the state department of health and the Cranston VNA loaned members of their nursing staffs to supplement the nursing service of the hospital. The State Department of Health, the VNA of Pawtucket and St. Joseph's Hospital loaned

their physical therapists for assistance during the epidemic.

Practical nurses and attendants, Red Cross nurse's aides and other volunteers gave splendid service in supplementing nursing needs. In several places parents came to the hospitals to take care of their own children.

Army and navy nurses and corpsmen were assigned to some civilian hospitals to gain experience. The junior and senior medical students at the University of Kansas worked in 6-hour shifts during the epidemic to gain firsthand experience in the care of infantile paralysis patients, including the nursing care.

HOME CARE AND SUPERVISION

Although efforts were made to hospitalize patients during the acute stage insofar as possible, public health nurses in many localities gave and taught nursing care in the home both during and following the acute stage. A considerable amount of home care was required in Utah and Chicago.

Public health nurses in all communities played an important part in the early recognition of symptoms which might indicate infantile paralysis and assisted families when necessary in arrangements for medical care. Their many home contacts provided opportunities to interpret measures which the health department had advised for control of the epidemic and to give information which would help allay the fear and panic of parents.

PREPARATION IN NEWER TECHNICS

Although the shortage of nurses and physical therapists with preparation in newer technics of treatment was acute the situation would have been more critical if some communities had not prepared in advance. The National Foundation for Infantile Paralysis and its local chapters financed training for more than 300 physical therapists and a considerable number of nurses received aid for short courses.

California reports that at the beginning of the 1943 epidemic 79 physical therapists and 150 nurses in the state had already received instruction in the Kenny technics. Even so this number was far from sufficient to provide the necessary care for more than 2,000 patients so the National Foundation for Infantile Paralysis assisted in procuring additional personnel. Several physical therapists were assigned to the California State Department of Health and their services were made available to local communities where the need was greatest.

In some communities where no physical therapy service was available, either in the hospital or public health nursing agency, attempts had been made to anticipate the demand for such services in an epidemic by awarding scholarships to nurses for a course in nursing and muscle re-education technics in the care of patients with infantile paralysis. The length of this type of course ranged from 4 to 6 months. This plan for the most part has not proved satisfactory either for the community or the nurse. If an epidemic did not occur the nurse had no opportunity to use her skills since she was not qualified in the entire field of physical therapy. She either returned to general nursing or went to another locality. Some communities which had financed such training found themselves without a qualified person when an outbreak occurred later.

Many nurses who had taken this specific training recognized its inadequacies in a generalized field of physical therapy and later took an approved course in physical therapy. Such courses usually include instruction in the Kenny technics of heat and muscle re-education.

CORRELATION OF NURSING AND PHYSICAL THERAPY SERVICES

In many instances hospital and public health nurses without physical therapy training were taught how to carry out muscle stimulation and passive range of

joint motion. These technics were also taught to parents. Those who participated in these procedures had the opportunity of giving a return demonstration and of having frequent supervision from the physical therapist. Administrative planning in regard to the assignment and hours of nurses is essential if nurses are to assume these additional responsibilities. In one hospital two or three nurses were given intensive instruction in these procedures and their schedule of working hours was arranged so that one of them was always on duty.

Many hospitals and public health nursing agencies commented on the value of specific written instructions for the care of each patient. These instructions which were worked out by the medical, nursing and physical therapy staff included such information as areas to be packed and frequency, positions to be maintained in bed, and muscles to be stimulated. Cooperative planning between physical therapists and nurses has developed the interest of the nurses in learning more about functional anatomy and has resulted in better care for the patients.

VARIATIONS IN TREATMENT

Communicable Disease Technic. Modification of customary routines of isolation procedure were reported in many communities. Institutions caring for large numbers of polio patients used precautionary technics for groups rather than for the individual. In most instances burning of nasal discharges and disinfection of stools were carried out. Modifications were made according to recommendations of the health department and the attending physician.

Moist Heat. Lay-on packs, in both prone and supine positions, were used extensively in the stage of painful spasm since these require less handling of the patient. Packs were applied whenever necessary for the relief of pain and patients were not disturbed for packs if they were comfortable. When the pin-on packs were used, the frequency of application ranged from 4 to 8 per day. In some institutions packs were applied for 1 hour, 4 times a day. Usually packs were omitted on Sundays in the hospitals. The differences in frequency of application did not depend entirely upon the available personnel but upon the condition of individual patients as determined by the attending physician based upon clinical observations made by the physician, nurses and physical therapists.

During the convalescent stage there is a definite trend away from continuing packs for an indefinite period. Other forms of moist heat are being used, such as alternate warm and cool packs, pool, whirlpool, and intensive packing of localized areas immediately preceding stretching. Physicians are agreed that further study is needed to evaluate the effects of the various forms of heat in the treatment of infantile paralysis.

Prevention of Contractures. There is a great variation in the length of time required for the attainment of complete passive range of joint motion. Persistence of tightness in the calf muscles and plantar fascia, sometimes for several months despite intensive packing, has led to a more immediate use of the foot board. Careful stretching of muscles which show a tendency to contracture is now being instituted even within the first few weeks. Because of the difficulty in keeping small children against the footboard, night splints for the feet have sometimes been prescribed. In some places splints have also been used during the day after the packs have been applied.

PLANNING FOR THE FUTURE

Plans to meet nursing needs in epidemics of infantile paralysis should be made as a part of the total community plan. Since control of communicable disease is a function of the health department, it is logical to expect the health

officer to assume leadership in the total plan. Because care of infantile paralysis may require long-term treatment, plans for care in any one stage of the disease cannot be made without consideration of resources and personnel needed for treatment in all stages.

In some communities, an overall planning committee has been appointed to work with the health officer in formulating plans. Representation has included the hospital administrator and the director of nursing service in the isolation hospital, the orthopedic surgeon, the pediatrician, the directors of nursing in whatever institutions are to be utilized for convalescent care, the directors of public health nursing agencies responsible for home follow-up, the director of state services for crippled children, and the chairman of the local chapter of the National Foundation for Infantile Paralysis. It is desirable also that representatives of professional organizations concerned with various phases of the care of patients with infantile paralysis such as medical, nursing, physical therapy and social services be included.

Essentials considered by the planning committee are (1) the availability of beds for care in acute and convalescent stages (2) the method by which necessary equipment such as respirators, materials for packs and their application may be procured if they are not already available (3) what professional personnel is available for medical, nursing, physical therapy and social services (4) ways in which voluntary groups may be of assistance. If any of these resources in the community are inadequate, the committee plans for adjustments.

Among the more critical problems during the 1943 epidemic were the shortage of nurses and physical therapists in relation to the number of patients, and the even greater shortage of persons qualified to teach the newer technics in treatment.

Experience showed that much of the nursing care, except for critically ill patients, could be carried out by non-nurse helpers—attendants, parents, nurse's aides and other volunteer workers. Public health nurses participated in teaching and supervising these workers and have a responsibility to participate in future plans for the teaching and supervising of these groups.

Public health nurses also should help interpret to the community the need for a sufficient number of orthopedic nurses and physical therapists qualified in the care of infantile paralysis patients, and should encourage preparation of such workers.

Financial help in securing postgraduate preparation in orthopedic nursing and basic preparation in physical therapy has been made possible from both official state and federal agencies and from private sources. For example, the National Foundation for Infantile Paralysis has granted funds to the National Organization for Public Health Nursing and to the National League of Nursing Education to provide scholarships to qualified nurses in preparation for orthopedic nursing and physical therapy.* Local groups such as service clubs and chapters of the Foundation have awarded scholarships for preparation in basic physical therapy to nurses employed either in hospitals or public health agencies, to assure the community of the services of a well-prepared physical therapist should an epidemic strike.

The 1943 epidemic has given evidence that the public health nurse has a very important part to play in meeting epidemics of poliomyelitis. She will have an even more important part in future epidemics as she realizes more fully the possibilities in increasing correlation of agency services and in utilizing to its fullest extent, community interest and cooperation.

*Information may be obtained from the American Physiotherapy Association, 1790 Broadway, New York 19, N. Y., in regard to the various sources for scholarship assistance for basic preparation in physical therapy.

Nurses United for War Service

By ELMIRA B. WICKENDEN, R.N.

IN PRESENTING this report to three of our member agencies, we shall pause only for a brief review of the profession's war activities during the two-year period since the last Biennial Convention. We feel that most of you have worked very closely with the program carried on by state and local nursing councils and that, as the National Council approaches the close of its fourth year, there are few nurses anywhere who are not familiar with its coordinated activities. The warp and woof of the program has been woven monthly into the pages of PUBLIC HEALTH NURSING and of the *American Journal of Nursing*, while the pattern has been set through the faithful and continuous work of the local groups.

This is your nursing council, your device for dealing quickly and decisively with the issues of wartime nursing. Through the Council your various organizations have worked together, your leaders have consulted with each other and with the Council staff, and when action has been taken it has been cooperative action. It may not always arise from unanimous opinion—for certainly in so large a profession there is bound to be divergence of viewpoints—but it has been cooperative, and we deeply appreciate the fact.

While many time-worn concepts and traditions have gone through the refining fire of a crisis which has brought necessary change and adjustment, it is equally true that the great and profound experiences of the last three years have, in many ways, made for progress and new life.

SUPPLY AND DISTRIBUTION

The major development of the past two years has been the establishment under government auspices of two units vitally linked with the supply and with the distribution of nursing personnel. Both the U.S. Cadet Nurse Corps, and the Procurement and Assignment Service for Nurses under the War Manpower Commission, were outgrowths of the profession's planning and desires. While supported by tax funds, their units are guided by distinguished and able members of the nursing profession who have worked in such close cooperation with the Council, through interchanging representation on boards and committees and through daily clearance of program and plans between staffs, that the total planning and execution of all war activities goes on as one project. We have reason to be grateful for this spirit of cooperation and determination to live up to the best traditions of the profession.

Though the Federal Government directs these programs and to an extensive degree finances them, procedures adopted are developed by nurses from among you, and the actual execution of plans depends in large measure on the nurses in your own state and in your home town. These facts place a heavy burden upon state and local nursing councils, not only to coordinate the total war activities of the profession but also to carry on an active program, especially through their student recruitment and their procurement and assignment committees. Governmental activity is directed through these two committees of the nursing councils rather

than through regional and other branch offices of the U. S. Public Health Service and the War Manpower Commission.

State and Local Responsibility

This increasing responsibility in the state and local area is a parallel to the development of federal nursing units and constitutes a second major development of the past two years. Thus a coordinated program is insured and the direction kept under the proper authority—the nursing group.

If the total nursing needs are to be met; if shortages are to be understood and dealt with constructively; if future planning is to have the support of all groups concerned with nursing care, the nursing council must be composed of all elements in the community directly affected. This means that nurses and consumer are both interested. No lone and overworked group of nurses can hope to achieve the results brought about by the joint efforts of the profession and the interested public. During this trying period in its history, nursing has made new and valuable friends who are eager to help now and later. The councils, therefore, need to become strong, coordinating units, furnishing a central place for all pooling and planning. In several states, where the representation is most adequate, great gains have been made in arousing public interest and in securing financial support. On the other hand, where only nursing agencies make up the council, the community leaders, having no voice in plans or decisions, are tempted to make plans of their own independently. As a National Council, we have broadened our base of board and committee representation, and are finding it a vitalizing process.

If you were to step behind the scenes for a few moments and visit the offices of the National Council, you might understand why it is hard to sum up our activities. Every few months the emphases of the committees and staff must shift as new wartime developments require. Yet we have certain continuing emphases.

Student Recruitment

Student recruitment, of course, is one. Quotas are recommended by a special committee of the Council which studies total needs and resources, and the Council takes action upon them. Studies such as these, together with many conferences, led to the passage of the Bolton Act, which is truly a child of the nursing profession and which relies on the profession for its successful growth and development.

A stronger organization of state and local recruitment committees has been promoted this year with the cooperation of the U. S. Public Health Service and the American Hospital Association. In a majority of states a recruitment officer and a deputy have been appointed by the U. S. Public Health Service with official status, a travel allowance, and franking privilege for mail.

The Clearing Bureau is another cooperative project. Two years ago, after the Nursing Information Bureau had found the volume of inquiries mounting sky-high, the Council established its Clearing Bureau to centralize the correspondence with prospective students who responded to our first publicity in radio, press, and magazines. During the last half of 1942, wholly from private funds, we answered 19,000 inquiries. Last year, 1943, functioning during the last half with greatly increased volume and tempo under Bolton Act funds, we answered 219,000 inquiries. Box 88 carried on in the same offices and under direction of the Council even after it became a governmental unit.

The college field program, also financed by contract with the U. S. Public Health Service, last year brought counselors on nursing to 612 colleges, stimulating the interest of both faculty and students and

bringing the national prestige of nursing into a field where the competition of the women's military services is keen. We were concerned, too, that emphasis on accelerated programs in nursing should not reflect unfavorably on the schools offering degree programs, nor divert college women from those schools where they could learn to make their maximum contribution to nursing. We are happy to say that the college project is to be repeated this fall.

Distribution of Service

Distribution of nursing service has been a major concern of the Council from the beginning. Two years ago, the Council published "Distribution of Nursing Service During War" and "Priorities for Nurses" in an effort to prepare for the Procurement and Assignment Service which, last July, was established under the War Manpower Commission.

Its development is familiar to all of you. Certainly it is one of the most challenging tasks a women's professional organization has ever been asked to carry out, and we as nurses may feel a modest pride in being thus far the only woman's profession considered so essential to the winning of the war that we have been singled out for special classification procedures.

One new task has developed upon us at the Council—the setting up of a National Classification Committee operating under Procurement and Assignment Service. This Committee is now classifying nurses whose work takes them across state lines and who are thus not within the jurisdiction of any one state committee.

In addition to the two continuous programs of student recruitment and procurement and assignment, the National Council has given consideration to other needs and has attempted to find solutions to other pressing problems. Among these are: the intelligent use of the practical nurse; a square deal for the Negro nurse, both in civilian and military services; a more widespread use of the retired nurse who could return to part-time duty; and support of a greater use of nurse's aides. Some of these problems have roots that go deeper than those of the war emergency, and those which have long-term implications have been turned over to the member agencies of the National Council, whose interests they are, for final solution. Such problems, however, as those concerning wartime shortages of nursing service have been carried on by the Council.

Recruits for Practical Nursing

In our huge daily mail from applicants are many letters from young women who are ineligible for a professional nurse's training. To those of this group who seem to have a sincere interest in nursing, we have suggested preparation as a practical nurse. Lists of such applicants have been sent to schools for practical nurses approved either under state boards of nurse examiners, state nurses' associations or, in a few states where no professional control is found, to good schools approved by the National Association of Practical Nurse Education, an organization made up of registered nurses directing these schools, practical nurse representatives and interested lay persons. A recruitment leaflet has been distributed by the Council, and a second pamphlet has been jointly prepared and distributed by the General Federation of Women's Clubs and the Council. It has been hoped that by these measures the enormous demand on the part of hospitals, doctors, and homes for a secondary level of care could be met in an organized and controlled way while the emergency was so acute. There is a real and urgent need for meeting the pressure on the part of the public and the growing body of practical nurses with a permanent plan. Such a plan is already in the making

through a joint committee of our national nursing agencies.

Progress in Negro Nursing

Negro nurses are not being fully used in the war. The Navy does not enlist them, and the Army has only a few over 200 at the moment. Large numbers of Negro men are serving their country, and both the Army and Navy have given some officers' rank. The National Council, in June, 1943, sent the following resolution to the Surgeons General of both the Army and Navy:

> Be It Resolved—That Negro graduate registered nurses be appointed to the Army Nurse Corps and the Navy Nurse Corps on the same basis as any other American nurses who meet the professional requirements, as was done in the last war. And Be It Further Resolved that a copy of this resolution be sent to the Surgeon General of the Army Medical Corps and the Surgeon General of the Navy Medical Corps, with the earnest request that they give consideration to this problem at their earliest convenience.

Various communications have been exchanged since. A small study showing satisfactory results of the inclusion of Negro students in schools enrolling both white and Negro girls, and of the use of graduates of both groups in the same hospitals, was made for both services and findings were sent them. No change, however, has been made in these rulings, and large numbers of Negro nurses are still denied the chance to give their services to their country through military duty. The Council is still hoping to see these restrictions removed, and will use all the influence it can muster to speed the day.

Meantime, the Council's consultant on Negro nursing has been making a country-wide effort to increase and improve the educational and employment opportunities of Negro nurses. She has been instrumental in measurable achievements that range all the way from assisting in the setting up of a fine new centralized school of nursing at Hampton Institute, Virginia, to hand-picking promising young nurses for graduate study. Student recruitment for Negro applicants is coordinated with the regular work under Box 88. The program is carried on under a special grant of the General Education Board, which approved the first year's work to the extent of increasing the appropriation nearly 50 percent for 1944.

Postwar Planning

When we finally arrive at the welcome day that releases us from the terrific stress of war's activities, how ready are we to pick up the equally strenuous problems of readjustment? While the National Council is a war agency, so many of its activities have held serious implications for future policies and trends that it has been impossible to ignore all postwar planning. As a matter of fact, "postwar" is here already. The first wounded soldier sent back from overseas was a symbol of it, and we now have thousands of such symbols among us.

The Council has taken some exploratory steps during the past year through committees on domestic and foreign postwar planning. We have learned that among the agencies of the Council—and at present there are 13—every known problem in nursing, present and future, is being considered. In many of the states, studies to determine needs, and resources to meet the needs, are being made or anticipated; much thinking and planning is going on everywhere.

The most urgent and immediate move is to work out a blueprint for the future education, distribution, and remunerative employment of all nurses who wish to practice their profession. There seems to be no question of the need for as many nurses as we have now or shall have after the war, at our present rate of student admissions. But knowing this fact does not automatically prepare, place, or pay for

these nurses where they will do their best work or the most good.

Such problems known to us all are the joint responsibility of a number of groups, such as the profession itself, the American Hospital and other national hospital associations, the U. S. Public Health Service, UNRRA, Army and Navy, Veterans Administration, Children's Bureau, Indian Service, health departments, industry, psychiatric and tubercular hospitals, all of whom must be making plans for future nursing service. We need to know their plans; they need to know ours. It is not too soon to be moving along with these problems, but we must move together.

The National Nursing Council has presented to the three national boards meeting here in Buffalo the suggestion* that a National Nursing Planning Committee be set up whose program would be projected five years into the future. This plan, recommended by the Council and based upon a report by a joint committee representing your three organizations, calls for a coordinating group—at first within the Council—where all activities affecting postwar nursing might be brought for clearance and joint effort.

Surely this is only what we owe, we who are here at home, to the Army and Navy nurses who are carrying on so courageously away from home. It is only what we owe, as mature and responsible women, to the present 96,000 Cadet nurses and 20,000 other students who are looking forward so eagerly to entering our profession. We want for them and for all nurses an orderly postwar professional world, in which nursing can find its greatest satisfaction by making its maximum contribution to the health of the nation.

Nurses have the reputation of being unafraid. Whether it is a catastrophe at home, a foxhole under fire at the front, or the sight of pain and death in a hospital bed, we face it without fear because we must, and because our dedication is to something beyond fear.

Now as the Allies press forward to the final struggle overseas, we know that nurses are ready, poised with the armed forces, with our civilians at home, to do all that the crisis demands.

But beyond the invasion lie the hazards of demobilization. Can we as nurses face them with equal courage, with equal vision, with equal intelligence? We shall need to. Among us are some nurses whose reluctance to cooperate fully may be traced to the fear of the unknown future. Whatever we can do to remove that basic insecurity will be of the greatest possible moment to the whole profession, and thus may affect the health of all the people.

Another obstacle we may encounter is the fear that some traditional prerogative of one organization or another will be altered in a possible postwar shifting of functions. Is this a fear great enough to drive us back, or can we prove that we know how to meet it by planning and working together?

The voice of nursing will be stronger and clearer when these fears have been conquered. The world after the war will be largely the world that we, both as nurses and as responsible citizens, foresee now, and move heaven and earth to create.

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*Approved by the Boards of Directors of the ANA, NOPHN, and NLNE at a joint meeting, June 7, 1944, Biennial Convention, Buffalo, New York.

Report presented at Joint Meeting of ANA, NOPHN, and NLNE, Biennial Convention, Buffalo, New York, June 6, 1944.

Nursing in Vocational Rehabilitation

By DEAN A. CLARK, M.D.

IT IS a great privilege to present before the representatives of the National Organization for Public Health Nursing a description of the recently expanded Federal-State Vocational Rehabilitation Program. This program is, as you know, designed to rehabilitate into remunerative employment all the handicapped who can be rendered employable, or more advantageously employable, through vocational guidance, physical restoration, vocational training, and selective placement in industry, agriculture, sheltered workshops, or homebound work. Its success depends largely upon two factors: (1) how successfully our rehabilitation agencies secure, through cooperation with public and voluntary groups such as your own, the services required by the handicapped for their rehabilitation, and (2) how thoroughly understood is the program by the public generally and by organized groups of the community in particular so that full use can be made of it through the referral of suitable cases, through wide acceptance of its aims by the handicapped themselves and by employers and professional organizations.

Because of the importance of these factors, therefore, I especially appreciate the opportunity of discussing our plans with you.

Under the terms of the Barden-LaFollette Act, or Vocational Rehabilitation Act Amendments of 1943, as it is also known, passed by Congress July 6, 1943, any person in the United States or its territories who is handicapped for employment by reason of disability and who can benefit by rehabilitation services, may be eligible for such services, under the federal-state rehabilitation program. The program is primarily for the civilian handicapped, not for veterans with service-connected disabilities.

Veterans who believe their disabilities are service-connected should apply for compensation and for rehabilitation to the Veterans Administration, which is prepared to handle all such cases. If the disability is considered by the Veterans Administration not to have been caused or aggravated by military service and is therefore rated as non-service-connected, the veteran may still be eligible for our program and he should apply to the rehabilitation service of the state where he is residing.

Sometimes the process of adjudicating the veteran's claim for service-connection is necessarily long and complicated. In many states, the state rehabilitation service accepts handicapped veterans as clients during this interval, getting them started on some useful line of vocational training for their future employment. If their disabilities are later adjudged by the Veterans Administration to have been service-connected, the state agency simply transfers the case to the Veterans Administration, and the veteran continues with his vocational training under its auspices.

SIZE OF THE PROBLEM

How large, you may ask, is the problem of the civilian handicapped? The National Health Survey, conducted by the United States Public Health Service

in 1935-36, revealed that there were 23 million people in the United States with disabilities severe enough to be classified as employment handicaps. Of the 23 million, about 16 million were between 16 and 64, that is, of working age. Roughly speaking, half of these were women for whom the exact rate of employability is a little difficult to predict. Of the 8 million men who had such disabilities, it was felt by the National Health Survey that 6 million could secure suitable employment by selective placement alone, but that the other 2 million would require rehabilitation services in order to be suitably employed. Of these, a million and one-half would be able to enter ordinary industry and agriculture after receiving vocational training or physical restoration or both, while perhaps half a million would still be so severely handicapped that they could only be employed at home or in sheltered workshops.

That is not the whole story. That is merely the backlog which really has not been touched. In addition, every year we have about 800,000 newly disabled men. About the same proportion of these as of the backlog are thought to be employable without rehabilitation, which would leave about 200,000 suitably employable only after rehabilitation services. Of these, 150,000 would then be employable in ordinary industry and agriculture and 50,000 only in sheltered workshops or at home.

Of course many of these people are now employed, but not up to the standard of work that they could be doing, according to their capacities, if they received rehabilitation services. Remember too that all these figures are entirely exclusive of military casualties. In a permanent civilian program like ours, therefore—and I might say that although the amendments were presumably passed as a war manpower measure, the program is a permanent one and not limited by the duration of the war—we are losing ground continuously until we are rehabilitating at least 100,000 to 200,000 persons a year, because until we get to that point we will be falling behind the annual increment of disability in our civilian population.

So much then for the size of our problem.

FEDERAL PROVISIONS FOR REHABILITATION

What do the Barden-LaFollette amendments to the Rehabilitation Act provide to meet this problem? I think I had better refer back to the original law, the Vocational Rehabilitation Act of 1920, which was repassed every year until 1935, and then made a permanent law at the time of the passage of the Social Security Act.

Under this Act, there were grants-in-aid from the Federal Government to the states to provide vocational guidance, training, and placement services, and prosthetic appliances to handicapped individuals. The federal side of the program was handled in the Office of Education. In the states, the state boards of vocational education assumed the rehabilitation work. It was only for the physically disabled, not for the mentally or emotionally disabled. It included no physical restoration services, no special services for the blind. The federal authorization was limited by statute to $3,500,000 annually, which was distributed to the states according to their populations, on a 50-50 matching basis for both administrative and case service costs.

By the amendments of 1943, the federal law has been quite radically changed and it now provides authority for all the services essential for rehabilitation. It retains the basic essential features of vocational guidance, vocational training, and placement services, which are in any program the backbone of rehabilitation.

However, these services and the new services, which I shall mention in a moment, may be provided for the mentally

handicapped as well as the physically handicapped and there are special provisions for services for the blind. Medical or physical restoration services are now included, as is the use of federal funds to pay for the maintenance of the individual during his rehabilitation, and for the purpose of purchasing occupational tools and prosthetic appliances. The statutory ceiling on federal funds has been removed. Congress has simply bound itself here to match whatever the states appropriate under plans approved by the Federal Office of Vocational Rehabilitation, which was established by the Federal Security Administrator as a constituent unit of the Federal Security Agency to handle this program. The director is Michael J. Shortley.

The Federal Office, however, merely acts to supervise the federal grants-in-aid, to establish minimum standards for the use of the money, to certify funds to the states, and to give technical assistance to the states. The operation of the program remains in the hands of the state boards of vocational education or, in the case of the blind, the state agencies for the blind where such agencies are authorized by state law to furnish rehabilitation services. The matching formula is changed so that while costs of case services are still federally reimbursed to the extent of 50 percent, all state administrative costs and all services for war-disabled civilians are reimbursed 100 percent. The latter group includes members of the Citizens Defense Corps, Civil Air Patrol, Aircraft Warning Service, and merchant seamen injured in the line of duty.

I take it that this audience would be most interested in hearing about the physical restoration aspects of the expanded program.

There is in the federal Act no limitation as to the scope of the physical restoration services which may be provided. They may be medical services, surgical services, hospitalization up to 90 days in any one case, convalescent home care, physical therapy, occupational therapy, nursing in the home, office, clinic and hospital, drugs, dental care for employment handicaps, and other services. There are, however, some limitations or definitions as to the type of cases which may be brought into the picture.

LIMITATIONS UNDER ACT OF 1943

What are these limitations with regard to the type of cases acceptable for physical restoration? In the first place the individual must have a disability that is a substantial employment handic p. This limitation naturally applies to all services under the Act. That is what he Act is for.

For physical restoration services, the disability must be a static one. That is not the case for vocational training, guidance, or placement services. The intent of Congress in using the word "static" here was to differentiate this rehabilitation program of physical restoration from ordinary medical care for acute illness or injury. It is a little hard sometimes to know what is static in medicine but we are, with the help of our advisory committees, getting to a point where some definitions are now possible. In general we take the word to mean any disability that is relatively stable or slowly progressive. Thus a case of chronic glaucoma, for example, would not have to wait until blindness had occurred before treatment could be provided.

The third limitation with regard to physical restoration is that the disability, in addition to being an employment handicap and static, must be such that by appropriate treatment it is expected to be substantially reduced or eliminated within a reasonable period of time. The phrase "within a reasonable period of time" clearly is intended by Congress to distinguish this program from the long-term care of chronic illnesses that do not improve very much. The emphasis is thus upon reconstruction for employment—filling a gap in our publicly-sup-

ported medical care programs that has sadly needed filling for a long time.

Finally, there is a fourth limitation on medical services of a somewhat different character: the patient must be found to be in need of financial assistance if physical restoration is to be paid for with public funds. This is not, however, required for medical diagnosis. By federal regulation the states must provide all rehabilitation clients with complete medical examinations regardless of their financial resources, but for treatment the patient must be found to be in need of financial assistance. This is not true, either, for vocational training which may be furnished without regard to the economic resources of the client.

This pattern follows the traditional pattern in our states; that is, vocational training, which corresponds to public education, is available to all without regard to financial resources, whereas public medical services, as is generally true, are made available only on a needs basis.

FEDERAL ADMINISTRATION

Now, I shall give you a brief outline of how the provisions are being administered. There are 51 boards of vocational education including the District of Columbia, Hawaii and Puerto Rico, and 31 state agencies for the blind, so the Federal Office is dealing in this program with 82 separate agencies. Where there is no state agency for the blind, services for that group also are provided by the state board of vocational education.

To supervise the physical restoration aspects of this program, the Public Health Service has assigned two medical officers to act as the medical personnel of the Office of Vocational Rehabilitation. My associate is Dr. Jack Masur of New York, whom many of you know, I am sure, as the former assistant director of Montefiore Hospital and director of Lebanon Hospital. Within a short time now we hope also to have a medical social worker and a psychiatrist in our section and later, perhaps a chief nurse and other technical personnel, and very possibly, some medical officers in our regional offices. There are now eight general (nonmedical) regional representatives of our office stationed strategically in Chicago, San Francisco, Atlanta, Kansas City, Minneapolis, Denver, and two in Washington, D.C.

The Federal Office has an overall Rehabilitation Advisory Council and the physical rehabilitation section has a Professional Advisory Committee which is in a sense a subcommittee of the overall Council. The Professional Advisory Committee includes representatives of the branches of medicine most concerned with rehabilitation, and of hospital administration, nursing, medical social work, physical therapy, and occupational therapy. We are proud to have as our nursing representative, Marian G. Randall, who has long been prominent in the NOPHN.

This Committee met in Washington on March 3 and 4 and worked very hard for a full 8 hours a day, which the office of Vocational Rehabilitation much appreciated. It went over word by word our proposed policies for physical restoration and discussed them point by point. The Committee assisted us materially in producing reasonable minimum standards, at least in skeleton form. These have recently been published in the Manual of Policies, under the section on physical restoration.* I will mention a few of the federal requirements and recommendations for the states which came out of that committee meeting.

STATE ADMINISTRATION

In the first place, the states are required by the federal standards to have

*Federal Security Agency, Office of Vocational Rehabilitation. Manual of Policies, Section on Requirements and Recommendations for Physical Restoration Services. April 1, 1944. U. S. Government Printing Office, Washington, D. C.

in each state agency a supervisor of physical restoration. This person will presumably be a worker with experience in the medical field but not usually a physician. It could be a nurse, medical social worker, clinic administrator, or some other person who has worked in physical restoration or in a health or medical care program.

In the second place, each state agency is required to have a physician as medical (administrative) consultant, full- or part-time. Presumably most of these will be part-time.

Third, there is required a medical social work consultant, full- or part-time; fourth, a state professional advisory committee, which is to include representatives of medicine, nursing, hospital administration, and other related fields. The object of the professional advisory committee, of course, is to meet with the state agency on general matters, meeting seldom but assisting the state agency in determining overall policy. The function of the medical consultant is the day-by-day consultation which will be required in passing judgment on the case applications, implementation of standards, and in advising other sections of the state staff, particularly those concerned with vocational guidance, training, and placement.

PERSONNEL REQUIREMENTS

You may be interested, too, in the requirements regarding standards for the use of physicians, hospitals, nurses, and others who will provide case services. It is anticipated that most of the treatment services under these programs will be specialty services. By and large, the types of disability which are employment handicaps, which will be reckoned as static and are remediable, will require specialty services, such as orthopedics, ophthalmology, tuberculosis work, psychiatry. So we have concentrated, in the standards required of the states, on the specialty services. General medical examinations may be done by any physician licensed to practice medicine and surgery, but the specialty standards are stricter. So far as possible, in the specialties in which American medical specialty boards exist, the states are asked to use physicians certified by these specialty boards.

Where there are real shortages of such certified specialists, then physicians who have met the experience and education requirements for admission to the specialty board examinations may be considered for use as specialists. In specialties in which there are no medical specialty boards—and there are quite a few of them, such, for example, as physical medicine and tuberculosis—the states are asked to draw up with their advisory committees standards which will show the federal office how they will choose specialists in those fields. Finally a provision is made that individual specialists may be approved by the state advisory committee in particular instances.

With regard to hospitals, the states are limited except in special instances, each one of which will have to be explained, to the use of hospitals approved by the American College of Surgeons. The *recommendations* regarding hospitals go further. It is recommended that the larger hospitals of over 100 beds be used where available, especially those which have well developed medical and nursing specialty services, medical social service, occupational therapy, and physical therapy. It is further recommended that, so far as practicable, a hospital approved for residency by the American Medical Association in a given specialty be used for cases requiring treatment in that specialty. In other words, we should like to see the states send eye cases, for example, only to those hospitals which are approved for residencies in ophthalmology. This recommendation cannot be applied universally but it will

help in setting up high standards where it can be used.

With respect to nurses, the states are asked to apply the following standards: (1) for graduate nurses, registration or eligibility for registration under the laws of the state (2) for public health nurses, fulfillment of the qualifications recommended by the National Organization for Public Health Nursing for 1940-45 (3) for practical nurses, registration or eligibility for registration under the laws of the state (where such laws exist), and utilization of practical nurses only under the supervision of graduate nurses employed by the official or voluntary health agency responsible for the service.

PAYMENT FOR SERVICE

There is one other point which might be of interest, namely, the way in which physicians, nurses, hospitals, and others may be paid for their services under this program. The Manual of Policies simply says that the states may choose whatever method they wish for paying physicians, nurses and other professional personnel. They may be employed on full- or part-time salary, or they may be utilized on the basis of fees paid per case, per visit, or per day. They may also be utilized through payments to clinics, hospitals, visiting nurse associations, or other official and voluntary agencies with nurses on their staffs, in whatever way the states may find most suitable under their particular circumstances.

However, if the states are planning to pay any personnel on a part- or full-time salary basis, the salary scale and personnel qualifications must be submitted as a part of the state plans to the Federal Office for approval. If the states are paying on a fee basis, the fee schedules must be submitted for approval and they may not exceed those utilized in programs for crippled children, or workmen's compensation, or those of the Veterans Administration, or the U. S. Employees Compensation Commission, whichever the state may wish to use, thus allowing the states leeway in establishing fees.

With regard to hospitals, it is required that payment be made on all-inclusive per diem rates. It is not required that these rates be based on cost, but it is recommended very strongly that payment be made on the cost basis in use in the crippled children's program and in the emergency maternity and infant care program, supervised by the Children's Bureau. We are recommending not a similar method of cost accounting but an identical one, so that a hospital participating in both of these programs would fill out but one form each year, sending one properly certified copy to the state health department for the EMIC and another to the state board of vocational education for the rehabilitation program.

The states are not obliged to pay the hospitals on the basis of cost, but they are required to use the all-inclusive per diem method and this may not exceed cost. Nursing in the hospital would ordinarily be paid for, therefore, as a part of the per diem rate. Certain unusual services, if they are not paid for by the hospital out of its own funds, may be paid for separately by the state agency if required. Such items might include, for instance, blood donors, special duty nursing, prosthetic appliances, or physical therapy, but only when the hospital has not paid for them.

PROFESSIONAL COOPERATION ESSENTIAL

These are the principal provisions of the program, particularly those dealing with physical restoration. I want to emphasize that in planning and executing all of this, the Federal Office has urged the state rehabilitation agencies to work closely with existing official and voluntary health agencies in the respective states. In particular, it is recommended that state rehabilitation agencies seek the advice of state health departments, crippled children's divisions, and of medical, hospital and nursing organizations,

in drawing up their programs. It is urged that so far as practicable this new program follow the policies and procedures of existing programs and agencies so that there will be a minimum of duplication and misunderstanding, and a maximum of collaboration. Public health nurses, it is hoped, will be prepared in their states to offer advice and aid to the rehabilitation agencies in establishing and in operating their programs.

Vocational rehabilitation is not a large program as yet. Last year 42,000 handicapped persons were rehabilitated, and in the last 23 years but 210,000, under the limited authority existing during that time. It is easy to see by comparing these figures with those given earlier that this has hardly made a dent in the potential caseload. We expect to expand rapidly. This year we hope for 55,000 rehabilitations, next year nearly 80,000. But we will not be satisfied until we are rehabilitating into remunerative employment at least 100,000 to 200,000 persons annually, and thus approaching the point where we will be keeping up with the annual increment of disability and, we hope, biting into the huge backlog.

To do this, we shall need and we are counting on the cooperation of all professions working in this field, such as your own. We shall need you badly to furnish the services required by our clients, and at last we are able to pay you a fair return for these services. We shall need you also to send us cases. You in public health nursing have a unique opportunity in the health department, clinic, and home to see these handicapped people in their distress, to find them and tell them about this opportunity, and to tell us about the cases you find. I urge you to do this—without this aid, we shall not be able to do our job. It is an important job. Our nation will gain immeasurably in its future vitality and strength if we can assist our thousands of handicapped to turn themselves from dependents into contributors to our economic and social life; to cease being tax consumers and to become tax payers. It is a big job, and we look forward to working with you to accomplish it.

Presented at Council of Branches Open Discussion Meeting, Biennial Convention, Buffalo, New York, June 7, 1944 for the NOPHN Committee on Nursing Administration.

NOPHN Resolves—

(Continued from page 310)

every citizen, and that means must be found to bring medical and public health services within his reach, be it

RESOLVED, that the NOPHN favor the expansion of prepayment health insurance plans with provision for nursing service, including nursing care in the home. It believes that, in addition to voluntary effort, governmental assistance is necessary for attaining adequate distribution of health services.

X. WHEREAS, during the war both the nursing profession and the communities it serves have experienced the advantages of joint planning through the National Nursing Council for War Service and the state and local nursing councils, be it

RESOLVED, that the NOPHN encourage the continued active existence, in the postwar period, of national, state and local nursing councils based on a similar pattern.

RESOLUTIONS COMMITTEE
HELEN BEAN, R.N.
HAZEL V. DUDLEY, R.N.
A. MARY ROSS, R.N.
MRS. FREDERICK S. DELLENBAUGH
MRS. NAN A. COX HARE, R.N.
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Social Work—Its Role Now and Tomorrow

THE changing role of social work in the war emergency, in postwar planning, and in an expanding American economy of the future was explored from many angles at the seventeenth annual meeting of the National Conference of Social Work in Cleveland, Ohio, May 21 to 27. An earnest and critical self-analysis seemed to permeate the meetings this year as perhaps never before, as 4,200 workers representing a broad gamut of social agencies gathered to participate in this great forum on social needs and planning.

Searching questions on whether social workers are concerning themselves with the basic social issues of the times recurred in session after session. Many speakers echoed the misgiving of Eveline M. Burns of the National Planning Association that social work has taken a back seat, has allowed its negative, ameliorative side to predominate in the public mind, has given overemphasis to adjustment of the individual to his environment rather than endeavoring to change the unfavorable environment. Speaking at a provocative session of the Joint Committee of Trade Unions in Social Work on May 23, Dr. Burns challenged social workers to seize the opportunity to give leadership in meeting the problems that create a need for social work, to prepare themselves now for assuming an active part in the future when administration of social insurance against major hazards to continuity of income will gradually supplant public assistance and necessitate a reappraisal of social welfare services.

Social insurance against one major hazard, that of health breakdown, was discussed in a lively session on a health program for the nation, with Michael M. Davis as principal speaker and discussants representing organized medicine and organized labor. Tracing the developments of 12 years in the direction of such a program, Mr. Davis concluded that "the front has moved forward." He discussed the Wagner-Murray-Dingell Bill for social insurance including health insurance, calling for widespread open discussion of its provisions by all groups concerned—physicians, farmers, labor, businessmen, hospitals. He said the bill needs constructive analysis by friends of a broad preventive and medical care program, with amendment to improve its effectiveness, and unity of support for the principles it embodies.

More aggressive social action was called for by labor representatives who appeared on the program in some 14 meetings, including for the first time a general evening session given over entirely to organized labor. Especially significant was a session on participation of labor in social planning, with speakers from the Detroit Council of Social Agencies, Community Chests and Councils, and labor organizations. The trend toward labor representation on boards and community chest committees and the educational program to prepare workers for these new responsibilities were discussed. In this session and others it was pointed out that social work and labor have identical interests and goals in working for better standards of living and security for the masses of people, and that labor support strengthens the hand of

social workers in their efforts toward basic social changes. In the words of one speaker, "The technical skills of social work plus the powerful voice of labor make a strong combination."

The issue of equality of opportunity, with particular emphasis on racial relationships brought to a crisis by wartime pressures, was pointed up in many discussions, and the gap between the principles we say we stand for and our failure to apply them was repeatedly stressed. At one social action meeting the National Maritime Union's effective program of racial equality within the union was described by an NMU representative.

Community organization in all its ramifications, under public and private auspices, in urban and suburban and rural areas, was the subject of many sessions. Especially interesting were the two meetings on American War-Community Services, the group of six agencies which has developed a new pattern of coordinated approach to help communities under wartime pressure. The National Organization for Public Health Nursing is one of these agencies. This experiment of nationals in joint financing, planning and approach in order to serve local communities more effectively was described as one of the most salutary developments in social work today by Harry M. Carey, executive director of the Greater Boston Community Fund. Its plan was outlined by Perry B. Hall, executive secretary of AWCS.

The migration around our country of some twenty to thirty million people, a drastic intermixture of all parts of the United States, has brought critical health and social conditions to overburdened communities, many of which have no services or inadequate services to meet the need. The cleavage between old and new residents in these areas offers a grave problem. The tendency to stereotype all these newcomers as irresponsible transients is obviously inaccurate and unfair. Many are experienced in community activities, and have a definite contribution to make in the new locality. New patterns of community participation may emerge, Mr. Hall said, in cities and towns where concern with special problems that interfere with the war is leading to a recognition of long existing inadequacies.

The program of AWCS comprises field service offered in communities that have asked for help and have given some indication of local leadership, with the object of stimulating local administration and support—private or governmental—of needed services. The AWCS budget is grossly inadequate to the enormous need and demand, but it hopes that local community chests will increasingly assume a share of responsibility for help to these critical areas in our country.

Volunteer service received more attention this year than ever before, with evidence of a trend toward employment of a full-time person in charge of volunteers in large agencies, and delegation of responsibility as a part-time job to a staff member in smaller agencies. The necessity for inclusion of some preparation on this important phase of social work administration in schools of social work is increasingly recognized.

Outstanding among new war services was the program under Selective Service for securing significant information for use of induction centers in medical examinations. Social workers and public health nurses have participated in gathering histories, especially in relation to psychiatric disability that may lead to breakdowns in service. Intensely interesting was the work of a psychiatric clinic in a military station hospital, described by three young men in uniform who serve as social workers to take histories, make psychological tests, and assist in the treatment of men whose reactions to the traumatic experiences of military life have brought disabling symptoms. The readjustment in civilian life of servicemen with medical discharges, particularly those for psychiatric causes, received

thoughtful attention. One city has a course for employers on the assimilation of these men in industry.

A thrilling new service is the cooperative program for merchant seamen—long neglected in peacetime — under the United Seaman's Service, War Shipping Administration, National Maritime Union, and U. S. Public Health Service. These men, exposed to hazards and stress beyond human endurance, are at last the concern of a broad health and social program that channels through the social worker in the hiring halls. Bertha Reynolds, well known to nurses, holds this position, and it was a very moving story she told.

The program of UNRRA, a group of 44 nations, for the war-devastated countries, was discussed in its many aspects, with one evening meeting devoted to the subject. It is significant that the share of the United States to date in the budget for this great service of relief and rehabilitation is equivalent to the cost of fighting the war for five days! —P.P.

RED CROSS NURSE'S AIDES IN COUNTY HEALTH DEPARTMENT

THE PRINCIPLE of lay cooperation has been recognized as of value in public health programs for a long time. However, in many health departments, the strife and turmoil of war has been responsible for demonstrating just how much could be done if we got together with our neighbors for a common purpose. This working together in Monroe County, Michigan, has brought about a relationship between Red Cross nurse's aides and the county health department which we consider enviable in these times of "rationed" personnel.

The cooperation starts with the training period. The director of the health department and the supervising nurse, who is also a member of the Nurse's Aide Committee, have met with each class to explain the functions of the health department and to give the aides an introduction to the work being done in preventive medicine. After graduation, aides have given three half days a week to the regular tuberculosis and venereal disease clinics. They have helped at the Christmas Seal X-ray clinics and have assisted in examinations done for the physical fitness program. Finally they have helped with immunizations and have done clerical work.

The work in the tuberculosis clinic gives the aides a chance to observe fluoroscopy and pneumothorax refills. They help to get patients ready for treatment and in the preparation of material for sterilization. They have the responsibility of giving each patient under treatment a container for the monthly sputum check. It is to be emphasized that the Red Cross aides supplement rather than replace the registered nurse. They are under professional supervision at all times. They can relieve the trained nurse of many things for which professional skill and responsibility are not necessary.

In venereal disease work an aide sets up for pelvic examinations and acts as chaperone. She also has an opportunity to observe treatment. At the Christmas Seal clinic the aides assist with registration, maintain an orderly flow of patients, and help the technician. They count pulses at physical fitness examinations and assist with infants and small children at immunizations.

Nurse's aides also assist with clerical work. They file negative laboratory reports and copy immunization dates on individual records. They also have transferred data from school enrollment sheets to individual student health records.

The unstinting energy and devotion which this group of women have given to clinic work are to a great extent responsible for smooth operational efficiency. The aides in return gain a knowledge of the work in preventive medicine and the satisfaction of knowing that they are doing something truly important in the protection of community health.

ALBERT E. HEUSTIS, M.D., DIRECTOR
RUTH HOWE PETY, R.N.,
SUPERVISING NURSE
MONROE COUNTY HEALTH DEPARTMENT,
MICHIGAN

Wisconsin Plans for Lay Participation

By POLLY MARINER STONE

WHEN we speak of the Lay Section of the Wisconsin State Organization for Public Health Nursing, we are telling of little yet accomplished since we are still young. We are telling rather of our plan of organization, much of which is still only a plan on paper. We are offering it as of possible interest to the citizens of those states where a state organization is being considered, or is in process of building.

The Wisconsin State Organization for Public Health Nursing was started in 1941. In 1942, two non-nurse members were elected to its board of directors. The Board appointed a committee to consider the matter of lay participation and submit a report, and a lay membership committee of two lay people and one nurse. The Lay Membership Committee met early in 1943 to formulate plans for building up a non-nurse membership. It was decided to have the president of the SOPHN write to all public health nurses in key positions in the state, asking them to propose not less than one nor more than six lay people from their respective localities or organizations, as charter members. The names of about 250 people were sent in. Letters of invitation to become charter members and an explanation of the purpose of the SOPHN were sent to these individuals with an application blank. Those that accepted the invitation were sent letters of welcome with their membership cards. Two more letters were sent during the summer about the annual meeting to be held in October giving the program and urging them to come. At the time of the meeting there were 110 charter members. Thirty-four attended the meeting.

In the meantime the Committee on Lay Participation early in 1943 had prepared a report which included a list of ten objectives for interested people other than nurses working in public health nursing in Wisconsin. These were:

1. To promote immediate organization of units of SOPHN corresponding to the Districts of the Wisconsin State Nurses' Association.
2. To stimulate organization of advisory lay committees for public health nursing services with ramifications into each community.
3. To encourage lay members to become informed regarding community health organization and its relationship to other agencies in order to provide the community with the best possible quality of service with minimum administrative cost and qualified personnel. An attempt should be made to coordinate the efforts of the various agencies interested in health.
4. To promote a community health council.
5. To serve as a group of informed citizens who recognize the need of a generalized public health nursing program executed by well qualified personnel.
6. To stimulate lay participation in the threefold nursing recruitment program to meet the emergency wartime need: a. student nurses, b. volunteer nurse's aides, c. home nursing classes.
7. To promote constructive legislation relating to public health nursing. To lend support to the State Bureau of Public Health Nursing for any proposed legislation.
8. To cooperate with the State League of Nursing Education and the State Bureau of Nursing Education through a joint committee to study and make recommendations to encourage more public health nursing in the basic school of nursing curriculum.
9. To complete a lay membership manual.
10. To stimulate reading of public health nursing material such as PUBLIC HEALTH NURSING magazine; *The Volunteer in Public Health*, Evelyn K. Davis; *Manual of Public Health Nursing; The Public Health Nurse in Action*, Marguerite Wales. A committee might be re-

sponsible for interesting local libraries in providing more material on health subjects.

As a means of securing interest the Committee further suggested that lay members be given definite responsibilities. Some possible activities mentioned were:

Make a survey of the amount and kind of immunization among the pre-school group in the community.
Survey the health education activities of the various agencies in the community.
Assume responsibility for health education publicity.
Carry on other activities as suggested in *Volunteer in Public Health Nursing.*

Additional activities that have been suggested are:

Promote development of loan cupboards.
Encourage distribution of literature pertaining to health.
Acquire printed material and start a public health nursing library.
Encourage and assist nutrition programs.
Offer assistance of organized lay groups to dental projects.
Give clerical assistance.
Further interest in development of mental hygiene programs. (Consult with the Bureau of Maternal and Child Health of the State Board of Health about development of such programs.)
Make surgical dressings.
Assist at clinics.

Finally the committee proposed that it study the present status of lay participation in health programs throughout the State by means of a questionnaire which it would prepare.

This report was presented at the annual meeting in October 1943. It is a program to be realized over a period of years.

At that meeting a Lay Section was created which met that same afternoon to make plans for organization. A temporary executive committee was appointed and a representative from each congressional district, that being the unit of division used in the state by the Wisconsin State Nurses' Association and the State Organization for Public Health Nursing. These district representatives were to act as chairmen in their districts and to form a council. Arrangements were made for a committee to formulate rules for the governing of the Lay Section and a committee to develop a lay membership manual. The objectives outlined by the Committee on Lay Participation were discussed further and the Section committed itself to the work of providing all assistance possible to public health nurses in Wisconsin. The question of the names and location of nurses to be approached was raised, and the director of the Bureau of Public Health Nursing of the State Board of Health agreed to provide this material. Copies of the minutes of the meeting, the report of the Committee on Lay Participation and a list of the charter members were sent all lay members, following the meeting.

Since we hold firmly to the principle that guidance must come from the nurses, an effort to make our program of assistance effective was launched by a letter from the president of the State Organization for Public Health Nursing to all key nurses in public health in the State. She sent them a copy of the report of the Committee on Lay Participation; asked them to study it and make plans for initiating a program of using lay assistance or expanding one already in existence. She told the nurses that Lay Section members would visit each one of them to offer this assistance.

Then a letter went from the chairman of the Section to each district representative. Enclosed was the information provided by the director of the Bureau of Public Health Nursing, which included the list of public health nurses in key positions, names of health officers, school superintendents, women members of county health committees and presidents of visiting nurse associations in that district. Each district representative received also a list of the non-nurse members in her district with information about their qualifications for or interest in public health nursing. She was asked to call

on each nurse, or have the nearest lay member do this, to find out what assistance the nurse was obtaining and what she wanted in addition. If there was a well established program of volunteer assistance, those providing it were to be enlisted as lay members. If no program, people were to be interested in helping the nurse and becoming lay members.

How is the plan working? In some places well enough to be really encouraging. It always works better where it is possible to visit the district representative and talk to her about what is to be accomplished. One hour's conversation is worth ten times the value of three month's correspondence. Unfortunately, in these days of restricted travel, to see people in widely separated areas of the state is a most difficult thing to do. Some of the northern counties of the state are particularly hard to reach and we feel personal contact is most important in that section. The chairman and vice-chairman of the Lay Section hope to get gasoline to make a trip there this summer or fall.

The first objective set forth by the Committee on Lay Participation was the formation of district units by nurse and lay members. These have been started in all but two districts and they are a help. Nurses and lay members meet at unit meetings and learn that they have the same interests and speak the same language—some of these units hold fairly frequent meetings. Wherever there is a visiting nurse association the habit of nurses and lay people working together is already a pattern and example. Giving the lay people certain definite tasks to be carried out under the nurses' supervision has helped to draw them together. The war has given impetus to this program and accented the potential value of the non-professional volunteer.

We have had disappointments. Recently we were asked to establish and man booths to give information about the Cadet Nurse Corps in theater lobbies where "Reward Unlimited" was playing. This brought forth some resignations where there had been a misunderstanding of what needed to be done to build an organization for immediate use. This prevents our giving assistance at once in some places but we shall build a stronger organization in these districts later. We are beginning this organization in wartime and want it to be immediately useful, but we realize the full scope of its usefulness lies in the postwar period.

We are planning a meeting of the Council of District Representatives for the end of June 1944. We want these chairmen from different parts of the state to tell each other what they are doing in their various districts so that they may learn from each other.

We feel it will be important to outline a definite new project for the lay members to undertake each year, and we think the Council should consider what is of most immediate importance to be undertaken next year.

Much of this is still a plan, but it is a plan we trust will eventually be successful with modifications that may become necessary. We believe that as one nurse convinces another how lay people can help in her work and as one lay person shows another the interest and value of working with the public health nurse, we will build a strong organization for public health nursing in Wisconsin.

Presented at the Council of Branches Open Discussion Meeting, Biennial Convention, Buffalo, New York, June 7, 1944.

Six-Lesson Course in Red Cross Home Nursing

ADDITION of a new streamlined course, "Six Lessons in Care of the Sick," to the program of the Red Cross Nursing Service will require thousands of nurse-instructors specially trained for the job, according to Olivia Peterson, national director, Red Cross Home Nursing.

"The overworked nurses who have remained in civilian duty since Pearl Harbor have contributed much of their time to teaching the standard and school course in Home Nursing," Miss Peterson said, in announcing the course. "We are most grateful to them for what they have done, but appeal to them to continue in this health education work that is so vital to the welfare of the nation."

Dr. Thomas Parran, Surgeon General, U. S. Public Health Service, in a recent interview with Miss Peterson and Dr. G. Foard McGinnes, national director, Medical and Health Service, American Red Cross, pledged the continued cooperation of the Public Health Service to the Home Nursing program.

"The continued shortage of physicians and professional nurses emphasizes the necessity of having some person in every home who is competent to give simple nursing care of the sick," said Dr. Parran. "Even in normal times, the basic job of keeping Americans well and on the job falls to the homemakers. In wartime, the homemaker's responsibility is greatly increased."

The "Six Lessons" were planned by Eula Butzerin, associate professor of nursing education, University of Chicago, and Elizabeth McCoy, assistant to the director of Home Nursing, American Red Cross, who have assisted in getting training conferences started in various sections of the country. Teaching methods developed by the Training within Industry Service of the War Manpower Commission have been applied to the teaching of the "Six Lessons" with a view to giving instruction in certain skills as safely and quickly as possible. The course has been worked out with the help of Training within Industry Service personnel who have been loaned to the Red Cross to introduce the system to nurse-instructors and lay groups.

The Red Cross Home Nursing Division is convinced that public health nurses will find classwork among clinic and neighborhood groups a great help in their work of bedside care. Women who have taken this fundamental course will be much better prepared to understand the instruction given during the short time possible in home visits. Busy nurses who cannot give the time to teach the standard course may find time to teach the "Six Lessons."

The course is limited to procedures selected from the standard Home Nursing course because they seem basic and fundamental, and most frequently needed by those who care for the sick at home.

Titles of the "Six Lessons in Care of the Sick" are:

1. *When Sickness Occurs.* Handwashing, waste disposal, symptoms of illness, care of the thermometer, taking of a temperature, inspection of the throat, and making of a daily record for the patient are taught.

2. *The Patient Goes to Bed.* Includes making an occupied bed, learning to move a bed patient with ease, making an improvised back rest, and giving the bedpan.

3. *The Clean and Well-groomed Bed Patient.* Deals with the cleansing bed bath and other personal grooming services.

4. *Food and Medicine for the Sick at Home.* An attractive and nutritious food tray is served, and different medicines are given.

5. *Simple Treatments Ordered by the Doctor.* Includes the preparation and giving of a hot water bottle, an enema, a steam inhalation, and a hot wet compress.

6. *Review and Summary, Relating the Care of the Sick to the Control of Communicable Diseases.* A brief discussion of the relationship of the procedures learned to the control of communicable diseases. A robe and slippers are improvised for the patient who is allowed out of bed.

There is nothing new about the material presented in the class, nor does the method itself even presume to be a new venture in education. This method of teaching and of presenting precise help for instructors, however, is a new venture in Red Cross Home Nursing. Although for many years an acceptable educational principle has been that we "learn by doing"—that "telling alone is not enough"—that "showing alone is not enough"—the Red Cross has incorporated this knowledge into a package that can be used in its entirety by the trained Home Nursing instructor.

The outline provided for the instructor gives the pattern for the conduct of each class. It includes an explanation of the principles underlying each procedure, a presentation of each procedure by demonstration, with special stress on the important steps and key points, and last, but most significant to the whole, a plan for *supervised practice* by each student. The assignment for a lesson is given after the class is taught. The use of the textbook as a reference is emphasized throughout the classes. With the outline is a complete list of the equipment needed.

Adequate practice requires adequate equipment. For example, when teaching how to handle a thermometer and take, read, and record a temperature, 11 thermometers are used—one for each member of the class and one for the instructor. While the list of equipment may at first appear rather long, it is soon realized by the Home Nursing committees that the supplies are necessary for this type of laboratory instruction and that such *home* supplies are not particularly difficult to secure.

The "Six Lessons" can be completed in as short a time as 3 days for special conditions in rural areas, or in 3 weeks with two two-hour sessions weekly. The preferred time seems to be one or two weeks, the former being particularly acceptable to industrial groups. As a class member said, "Six lessons in six days seem much more possible to many people than six lessons in six weeks."

While this material may appear to be elementary, there are skills to be learned by the instructor in *timing*, in *adhering to a pattern*, and in *planning for adequate supervised practice* for each student. This means, therefore, that special preparation for teaching the "Six Lessons in Care of the Sick" is essential in order that instructors may understand the philosophy and reasons for this program, and may have an opportunity to learn, by experience under supervision, the pattern to be followed in presenting the content of the lessons in a 12-hour period. It is recognized that there may be several acceptable methods of performing any one procedure but for effective teaching and learning only one method—usually that given in the textbook—is used.

To assure a high level of instruction in the "Six Lessons" throughout the country, the Red Cross has undertaken an extensive training program for instructors, to be selected from those meeting requirements for authorization to teach the standard course. In order to carry this forward, plans are under way for two types of conferences (1) a two-weeks' conference for those who will teach instructors and (2) a one-week conference for instructors of lay groups. Conferences are limited to 10 members each, who must

have been selected carefully on the basis of physical health, emotional stability, and ability to adjust to new methods. Following the week of demonstration and practice of the lessons, there is a period of planned supervision while lay classes are taught by the instructors. Those who take the instruction are expected to conduct throughout the year at least five conferences or classes as the case may be. The cost of the program justifies this requirement.

Providing time for busy instructors to attend conferences will present a problem for both nurses and Red Cross chapters, but the enthusiasm already displayed by both instructors and lay persons who have been trained by this method leads to the conviction that the experience will be worth the effort. An instructor in an Ohio conference wrote, "The outline will give more volunteer instructors the assurance that they can teach the course. My attitude toward the course before coming to the conference was one of skepticism. After seeing the execution of the plan, my attitude is one of acceptance."

As experience has been gained during the conference periods of the past three months, this type of shortened course has proved itself worth while far beyond early expectations.

The "Six Lessons in Care of the Sick" may be followed by other groups of lessons such as "Mother and Baby Care," now being discussed with the U. S. Children's Bureau. As times goes on, other requests may be answered in other lessons. The course aims to meet the changing needs of a changing world in a very difficult period of its history.

Contact your Red Cross chapter if you want to teach the "Six Lessons."

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What other people think of us we value as a highly important measure of the worth-whileness of the service we offer. What we think of ourselves is apt to be an even more critical evaluation of our aims and progress. Following a time-honored custom of the Magazine, we asked a general member and a nurse member to hold their own personal and truthful mirrors up to the 1944 Biennial Convention to find out whether there would be reflected an image fair, vital, flexible or whether it would be unpleasant to look upon, lifeless, rigid and unbalanced. The stories which follow tell what two people—one from New England and one from the South—saw at the historic Buffalo meeting.

Convention Highlights

By HELEN J. ROLFE

IN MY efforts to be in three places at one time, to take advantage of the equally tempting programs at the Biennial in Buffalo, I could think of nothing but my childhood confusion over the three rings in the circus. As there, I wished it could be spread over a longer period of time so that nothing need be missed.

A smaller than usual, serious-minded lay group, made more tense by the invasion news on the second day, used every minute and every opportunity to get the latest and the best public health nursing information. To and from sessions, in cafeterias, hotel rooms and lobbies, special problems were discussed and experiences exchanged.

Postwar seemed to have taken the place of *war* in the program theme. In fact, it was felt that with the thousands of soldiers being returned to civilian life each month many postwar problems are already with us.

The discussion by and for lay members covered two topics. In the discussion on the "Future of Volunteer Programs," it was brought out that women will volunteer to do a job if convinced of the extreme necessity of their help; that discrimination must be used in selecting volunteers; that special training is essential and must be definite and interesting to keep enthusiasm at a high pitch and that supervision on the job is most important though not always foreseen, for some strange reason. It was thought that volunteers could be held after the war if made to feel that the community still needed them. In a larger and better service-to-the-sick program volunteers would be needed, even with no nurse scarcity.

In the discussion on "Community Health Nursing-Chest Council of Social Agencies Relationships" there was a less clearly-defined and agreed upon schedule. The trend seems to be for the Council to be the budgetary group and the Chest to do the fund raising. Details of the health side of the nationally known Syracuse Postwar City Plan were given and many constructive and usable points brought out.

One of the most attention-holding, thought-provoking and practical talks was on "The Nurse in Public Relations." A word more inclusive than "patient" and implying prevention as well as sick care is very much needed. An informal poll by the speaker had convinced him that there is no uniform or true conception of what a public health nurse is or what she does. It made a public relations job seem a "must" for every community.

And it made the announcement of the plans for a national public health nursing

day, in January 1945, seem opportune. A special committee from the Board and Committee Members Section has a program which will be as far reaching, as constructive and helpful as the SOPHN's and local boards will make it.

Two lay presentations of SOPHN projects were admirably made. Wisconsin, currently in the process of organizing, has outlined a procedure which could well be used as a pattern. Minnesota's lay section has been working on the educational and legislative steps in an effort to set up health districts throughout the state.

Gleanings from my notebook include such practical items as: Hartford's nursing committee invites three board members to each meeting until all have sat in once; Saginaw, Michigan, gives cards with mothers' class dates to all doctors, calls once a month for the doctors' lists of prenatals and gives one free visit in the home, after having a telephone call from the hospital saying that mother and baby are leaving; Providence uses the procurement and assignment list to locate inactive public health nurses for part-time service; York, Pennsylvania, gives night service, having had 139 night calls in May.

A delicious and attractive buffet supper, given by the Buffalo Visiting Nurse Association board members for the lay guests at the Biennial, was the festive event of the convention. It offered an opportunity for people to meet each other, as well as their hostesses, and to visit together under most pleasant circumstances.

Impressions of the Biennial Convention

By CHRISTINE CAUSEY, R.N.

IT WAS with a feeling of guilt that some of us boarded the train in the heat of early June to attend the Biennial Convention at Buffalo. Mixed with that feeling, however, and submerging it was the realization that never before in our history had there been a time of more importance to nurses and nursing. While history was being made on the battle fronts around the world, nursing history was also being made on all nursing fronts. In contributing our part to the war effort, in meeting the quotas for military service, in accelerating the basic nursing program, in the readjustment of all nursing services, in Procurement and Assignment, in the use of practical nurses, in the use of nurse's aides and volunteers we had learned much. We knew it was now time to take stock of all the changes which had taken place, to evaluate our accomplishments and plan for the future.

The programs of the Convention proved to be stocktaking and objective and forward thinking, as we had hoped. It was with a feeling of satisfaction and pride that as an SOPHN president, I attended the NOPHN board meeting and listened to the accounting of our officers. It was good to feel that the confidence of public health nurses had been well placed.

In thinking toward the future it was recognized that a large part of our war effort lay ahead; that public health must now lay the plans to fight disease and fear and malnutrition and all the other health evils which have resulted from the war.

Where at first that seemed too gigantic a problem, the way became clearer when we recognized our part in the cooperative

planning of all health and welfare agencies.

I am sure the SOPHN's of the nation are proud of our leaders, and proud of the clarity with which they are thinking in relation to the nursing profession and the health needs of the nation.

The adoption of the Resolutions at the final business meeting placed upon us all as members an obligation to see that they are carried out. We as citizens must use our influence in our daily contacts to teach the principles of democracy and to encourage all groups to participate in planning for our separate community's needs. In the words of John Paul Jones, "We have not yet begun to fight." Let us be certain that the responsibility which has been given us has not been misplaced.

A COMMUNICABLE DISEASE NURSING INSTITUTE

Staff education planned to meet an expressed need by public health nurses in Iowa was exemplified in a one-day institute in Des Moines, Iowa, May 12, 1944, sponsored by the Iowa State Department of Health and the Iowa State Organization for Public Health Nursing. Each public health nurse was given something tangible that would help her develop the local communicable disease program and guide her in planning her own services so that she could make it more effective.

There was active participation by all nurses attending the institute which opened with a discussion of the elements common to all communicable disease nursing in a generalized program. The general principles of nursing care were followed by presentations illustrating community and home procedures in the control and prevention of scarlet fever. Two case histories were given where nursing services to the patient and the family were emphasized. A demonstration of home nursing technique was presented with a reader and a printed poster outlining the essential principles of the techniques. Emphasis throughout was placed upon the care of the patient rather than upon the disease.

The afternoon session was devoted to the presentation and review of educational exhibits: "The Bulletin Board," "Biologics Available," "Building Resistance Through Nutrition," and "A Graphic Picture of the Immunization Project." Improvised sickroom equipment was displayed and demonstrated by the Des Moines Red Cross home nursing instructors.

Important elements of the day-by-day communicable disease nursing, such as planning, selection of cases, case-finding, follow-up, and the use of community resources were interpreted throughout the program. However, each nurse was left at the end of the day with the admonition that the quality of communicable disease nursing service rendered in her community was her responsibility. Eleven thought-provoking questions, to be used in evaluating her communicable disease nursing service, were presented, so that the educational principles outlined and teaching aids could be applied in the local situations.

LILY HAGERMAN
PUBLIC HEALTH NURSING CONSULTANT,
DISTRICT 7, U. S. PUBLIC HEALTH SERVICE

Introducing the Senior Cadet Nurse to Public Health Nursing

By ELISABETH C. PHILLIPS, R.N.

MUCH thought has been given to the amount and nature of the instruction which should be planned for the cadet who is to spend her senior period with a public health nursing agency. We at the Visiting Nurse Service of New York (formerly the Henry Street Visiting Nurse Service) assume and hope that some cadets will remain on in public health nursing and some will return to the schools of nursing to become teachers and supervisors there. We therefore have kept the needs of both of these groups in mind. For those who elect to continue in the public health field it seems wise to include in the initial introduction sufficient materials and discussion to enable them to assume at the end of the period staff positions with considerable security and proficiency. For those who return to the hospital we want to provide a basis which will make the field experience as rich and meaningful as possible, so that their future teaching will reflect a broad understanding of community health problems. But at the beginning of the experience no one knows, the cadet least of all, which group will be which. Therefore, it is impossible to plan two separate introductions.

The philosophy, objectives and values of a public health nursing experience for senior cadets were discussed in the March issues of PUBLIC HEALTH NURSING and the *American Journal of Nursing*. We are now concerned with the actual program for these students, for students they remain as well as productive workers. We have frankly modeled the cadets' introduction on the plans which have been evolved over many years for introducing new staff members.

Each cadet is assigned to a local center where the supervisor places her under the guidance of a senior adviser who is an efficient and experienced staff nurse with a strong interest in teaching other nurses. (It is well to remember that good senior advisers do not "just happen" but in turn must have planned and simultaneous guidance from their supervisors.) The senior adviser plans observations for the cadet in each type of activity and selects a case load which will insure a well-rounded experience during the orientation period. She also observes the cadet in each type of organization activity in which the cadet is given responsibility, both in the home and in the office, and discusses these observations with both the cadet and the supervisor in order to plan with them the next steps in the cadet's orientation. This period of intensive training lasts from 2 to 4 months depending upon the ability of the cadet to master the complexity of the situation and meet the needs of her patients. At no time during the senior cadet period is the student completely responsible for a district of her own although she shares the responsibility with her senior adviser throughout its entire span.

In addition to individual guidance, group conferences, demonstrations and

case discussions are held. The conferences pertaining to local matters and the case discussions are held in the local office while those dealing with matters germane to the whole organization are carried on at the central office. During the first 2 months' experience a minimum of 50 hours is devoted to group work.

The 50 hours are divided as follows:

CENTRAL OFFICE CONFERENCES AND DEMONSTRATION

1. General Introductory Conference (3 hours). This is held the first day. At this time the cadet is told something of the history of the organization and its administrative setup. New York City as a whole is discussed but the peculiarities of the individual districts are omitted since that is covered in the local conferences later. At this first conference, too, the organization's personnel practices under which cadets will be working are reviewed for her.

2. After 3 or 4 days' observation in the field an entire day is devoted to conferences. In the morning there is a discussion of family and community health (3 hours). This comes, of course, after the cadet has been observing with her senior adviser in the field. The discussion centers around such questions as: Why was the visit made? What information did the nurse have before making the visit? In what type of community does the patient live? What did you observe of the patient's more immediate environment? How did the nurse approach the family and how did they respond to her? What did the nurse learn about the family? How? Why? And when did she learn it? What information regarding the health status of all the family members did the nurse obtain? Why did she do this? How did the nurse meet the family's needs as they saw them and as she saw them? What did the nurse record on the patient's record and on the bedside notes? How will these notes be helpful to her in the future? Were any fundamental community problems revealed through this visit?

3. The afternoon of the same day is devoted to conference and demonstration of the methods concerning the importance and techniques of the morbidity visit (3 hours). Included in this is a discussion of the functions of the public health nurse in the morbidity service, the source of calls and the part the nurse plays in case finding, the principles of case selection and the importance of medical care for the patient. There is a demonstration of the important points in the nurse's visit and discussion of the good ways of organizing her work and of giving care to the patient. The orthopedic implications of bedside nursing care are discussed in some detail as is the importance of good nutrition guidance. Considerable stress is put on the fact that the morbidity visit presents many opportunities for the nurse to teach families simple nursing procedures and health measures which will aid in the prevention of disease and the promotion of health. It is pointed out that when the nurse actually gives bedside care she has an excellent means of establishing a very fruitful relationship with the family which may prove to be most productive long after the morbidity situation is terminated.

*4. One week later an all-day conference concerning the role of the public health nurse in the maternity cycle is held. There are a number of demonstrations included in this conference such as the methods of doing urinalysis, determining blood pressure and bathing a newborn baby in the home.

*5. The next week another all-day conference is planned. In the morning (2½ hours) a discussion of methods of interviewing and determining family relationships is held.

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*Note: The sequence of the fourth, fifth and sixth conferences may be variable depending upon the total program.

*6. In the afternoon (3½ hours) the ways of caring for communicable disease patients in the home are demonstrated and discussed. The responsibility of the department of health and the means through which the visiting nurse service cooperates with it for the better control of communicable disease receive considerable attention.

7. Two weeks later a day and a half are devoted consecutively to family health supervision (9 hours). The values of health supervision from the family viewpoint are stressed and the important role which the public health nurse plays is discussed. We have divided health supervision into three major fields for purposes of discussion. While the emphasis and importance may vary at different age levels and at different times within a specific family, these three major fields remain in all family health supervision:

a. The need for a good understanding of the normal physiologic and mental changes occurring throughout life.

b. Ways in which the promotion of positive health may be accomplished.

c. Methods which will prevent disease (physical and mental) and lead to its early recognition.

8. The last conference (3 hours) held at the central office relates to the use of nursing records. The methods of record keeping and the use of them in preparing for a nursing visit are discussed in detail in the local districts so that this conference is devoted in the main to the use of records by the organization in its own planning of program as well as in the courts. We try to make clear the part which each individual record of the patient and nurse plays in the total organization scheme and how future plans are based on records that are kept today. We feel that this is very important because it helps the nurse to see how she too has a part in the total program of this large organization.

LOCAL CONFERENCES

1. During the first 2 weeks about 6 hours are devoted to discussing local situations and methods in which the nurse functions in both office and district.

2. Then each week for the first 2 months case discussions are held in the local centers which total approximately 12 hours. These are led by the supervisor and there is free participation on the part of all present.

INDIVIDUAL CONFERENCES

There are innumerable daily individual conferences with the senior adviser and the supervisor. We have not attempted to total the amount of time which goes into this form of teaching, although we feel that perhaps some of the most vital learning of all takes place at this time.

REPORTS

A daily experience card is kept by the cadet so that the senior adviser and supervisor can watch it and be sure that the nurse is having experience in all types of work. At the end of the first 2 weeks the senior adviser and the supervisor make a brief report on the cadet. During this time they have tried to determine whether or not the cadet is suited at this period in her development to the public health nursing field. However, it may be impossible to draw a definite conclusion before the end of one month's experience. The director of the school of nursing from which the cadet comes has already been promised a report at the end of the first 2 weeks in the field and this is sent to her immediately in order that she may make other arrangements for the senior period for those students who are unsuited to this type of work. At the end of 2 months we send a second report to the director of the school of nursing. However, in the future we are going to postpone this until after 3 months when we think that it will be much more indicative of her progress at

that time. No further reports are sent to the director of nursing until the end of the senior cadet period unless some unforeseen situation arises. However, all during the experience the supervisor keeps running notes on the progress which the student is making. This is our customary procedure for staff nurses.

It is easily seen that if this much group instruction is given, it is necessary that the cadets come to the organization in a group. This Spring we had one group of 6 who came on March 1, and one group of 5 who came on April 1. This, of course, was an expensive procedure since the group conferences had to be repeated. However, in the beginning one always expects a program to be less efficient. We have, of course, experienced difficulty in finding a date in the year which is satisfactory to cadets coming from a variety of schools. Because of the large numbers of new staff nurses and graduate students which we introduce to the field twice a year, we are somewhat limited as well in the times that we can well accept groups of cadets. We have decided to introduce a group of 15 to 20 cadets in September this year. These cadets can be admitted any day during the week of August 28. Very brief individual introductory conferences will be held followed by field observations, but the group conferences will be deferred until September 1. This is an experiment but one that we think is likely to prove satisfactory.

The cadets who come to this organization are expected to work the same length of work week as the rest of our staff nurses, namely 88 hours in any two-week period. They are paid $105 per month plus withholding taxes. No vacation allowance is granted but 6 holidays per year are given at the time they normally occur. Our usual policy of one day sick-time allowance per month worked is in effect for the senior cadets, so that in their six-month period they can be allowed six days' sick leave without any reduction in pay. Leaves of absence without salary for graduation, state board examinations, or necessary vacations can be arranged individually with the approval of the director of the school of nursing.

A "Bulletin of Information for Senior Cadets" has been prepared and is available upon request. Applications for the September 1944 group may be received from directors of nursing through August 1. Appointments are made by a committee and cadets showing the greatest promise will be appointed.

NATIONAL LEAGUE OF NURSING EDUCATION

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Marion W. Sheahan, R.N., Albany, N. Y.
Mary M. Roberts, R.N., New York, N. Y.

Community Action against Venereal Disease

By CHARLOTTE P. SMITH, R.N.

VENEREAL DISEASE education is not a new field of endeavor, for pioneers have already laid the foundations by doing the seemingly impossible task of bringing the words syphilis and gonorrhea into common usage. Yet, for the community conscious of its obligations to its people, there are many tasks still to be performed.

Since the primary purpose of the public health nurse is education in healthful living, here is a field where she can be of utmost usefulness. Through her daily contacts with all types of people she has unlimited opportunity to teach the true scientific facts about the venereal diseases. But beyond the teaching of individuals, the nurse doing public health work, if she is vitally interested, is now challenged to expand her field of venereal disease education to include the whole community. It can be done, because it has been done.

Venereal disease is a community problem because it is in the cities and towns that infections of syphilis and gonorrhea arise. Our soldiers and sailors are not being infected in their camps or on board their ships; it is in the communities that we must fight the battle against venereal disease. Sick men and women cannot fight nor work and it is easy to see what high venereal rates do to the war effort and to the life and vigor of industry. Physicians and nurses especially know the toll of human happiness and health taken by venereal diseases.

For the nurse who is planning to do a community educational program, here is outlined a working model, one which has been used successfully and one which can be adjusted to fit the particular community and its various problems.

FIRST of all, a successful program must reach all classes of people; it should not be directed at one particular group. The sponsorship of the local medical society is essential and most physicians are ready and eager to help because they realize the need. But they alone cannot accomplish a program of education and the cooperation of business men and women, schools, civic groups, churches and other professional groups is imperative. From such organizations the sponsoring groups should be organized, each member with a definite duty to perform. Set a time for the campaign and follow a planned schedule.

At the beginning of the campaign or shortly before, it is a good idea to hold a large meeting, possibly in a hotel or school building, for executive officers or representatives of all clubs, churches, police, women's organizations, newspapers, school officials, and others interested, so that the campaign and what it is hoped to accomplish can be explained to them. By doing this, much adverse criticism can be averted. Good speakers, the type to inspire enthusiasm for the campaign, should be obtained. Include on the program a representative of the

medical society, the mayor of the community, and professional men or women to speak directly about the various phases of the venereal disease problem. Also, if time allows, a motion picture can be shown. Above all, remember not to have the program so long that the audience becomes bored. Good planning will eliminate this possibility.

Good newspaper publicity is essential and fortunately most editors are willing to publish material given to them. They like to write their own editorials. Sometimes, however, if articles submitted to them appear too much like editorials they may use them as such, thus causing the material to be discarded by other papers. If there is more than one newspaper in the community, the person writing the publicity must remember to play no favorites but to give each paper an equal amount of news on the same subject at the same time. Articles on the history of syphilis, congenital syphilis, syphilis in industry, prostitution and gonorrhea are timely. Cartoons specifically relating to the problems of the community can be used to advantage because they will reach people who will not take time to read articles. For example, the topic, "syphilis in industry" can be effectively illustrated for an industrial town. Some papers are willing to assign a photographer to take human interest pictures of the treatment of syphilis, blood testing and laboratory work for venereal disease diagnosis. In such pictures it is not wise to expect actual patients to pose full-face but this handicap can be overcome by showing only the physician's or laboratory worker's face and a back view of the patient.

Radio stations can and will accept broadcasts. Of course, stations must be approached well in advance so as to secure time on their schedules. Program directors will assist in choosing appropriate hours for the type of broadcast to be used. During the day housewives will be most likely to listen, while during and shortly after the evening dinner hour the family group is assembled. Late at night a mixed adult group is more likely to tune in. Programs with well-selected local speakers are fine, especially if a roundtable type of discussion is planned. The participants might be physicians interested in venereal disease control work, police officials, representatives of churches and leaders of boys' and girls' clubs, also, if possible, a medical officer from the nearest military station. Each should discuss the relation of his group to the problem of venereal disease control. Try to have the speakers write their own ideas before the scripts are made up, so that when the program is on the air it will sound spontaneous. Remember also that the scripts must be passed by the Office of War Information before they are ready to be broadcast. Writing radio scripts is not a simple task for the uninitiated and it is well to seek professional advice so that the broadcast will sound finished. A little rehearsing before the time of the broadcast will not go amiss and helps, to some extent, in overcoming "mike fright" for those who have not had previous experience. As a supplement to live broadcasts very fine radio transcriptions are available.

POSTERS are a necessity because they reach people who are not otherwise reached by educational material. Numerous uses can be made of them. Specially prepared posters for men's and women's public washrooms are a possibility. These include washrooms in service stations, restaurants, taprooms, and industrial plants—in fact, every public washroom in the community. Eye-catching car cards in busses and streetcars serve a very useful purpose. Drugstores and business establishments, especially taprooms, can display colorful posters. However, it is well to remember that there is always the possibility of posters being

marred or marked by unscrupulous persons and they should be removed immediately if this takes place. Posters placed in washrooms are particularly liable to be damaged.

Literature for free distribution can be placed on drugstore counters, hotel desks and the like. It is surprising how much literature is taken and read by interested persons. Another means for dispensing literature is by way of the pay envelope of business and industry.

One of the most productive methods of reaching large numbers of people is through meetings for which speakers have been provided. Clubs and schools are anxious for information and are glad to have a chance to learn about the venereal diseases. But the speakers must be well chosen and sincere about their message. Professional people are perhaps the best, although well-informed lay people can do a remarkable piece of work. At meetings there is also the opportunity to give out free literature, and answer pertinent questions. The advantages of meetings are limitless. However, caution must be taken to prevent their becoming merely entertainment.

Motion pictures can be used as a part of the process of teaching at meetings with the picture chosen to suit the type of audience. Films on venereal disease have been prepared for use in commercial theaters as a part of their regular programs, and, since visual education is a powerful teaching medium, their use is particularly advantageous because of the large number of people they reach. You should attempt to get these commercial films shown in all the theaters of the community, not just the theaters patronized by a certain type of audience.

The task of organizing a community venereal disease educational program is not a simple one and many complex problems must be met daily. There are many pitfalls, some small and others large, but all can be overcome if the resolve to make the campaign a success is high enough. And a public health nurse well-informed on the venereal diseases and their multiple problems can be of invaluable assistance in all phases of the campaign. But she cannot do the job alone; she must have advice, support and a great lot of assistance.

The state departments of health, the United States Public Health Service and the American Social Hygiene Association are ready and willing to help in planning and executing a venereal disease educational campaign, although it should be said that a program of short duration is of little value unless the community carries through with broad plans for social reform and continuing the work begun. A well-educated and informed citizenry will demand that this be done.

So, Public Health Nurses, a challenge has been placed before us. Are we willing to accept it and join in this part of the war on the home front to help make our towns and cities healthier and happier places in which to live in the world of tomorrow?

NOPHN Board Meeting

THE NOPHN Board held a meeting in Buffalo on Monday evening, June 5, 1944, at the time of the NOPHN Biennial Business Meeting. Board members present were Marion G. Howell, presiding, Marion W. Sheahan, Ruth Houlton, secretary, Helen Bean, Leah M. Blaisdell, Mrs. Frederick S. Dellenbaugh, Laura A. Draper, Mrs. David K. Ford, Alma C. Haupt, Emilie G. Sargent, and Mrs. Donald C. Shepard.

In addition, the following guests attended: Mrs. S. Emlem Stokes, chairman of the Board and Committee Members Section, Mellie Palmer, chairman of the School Nursing Section, and representatives of SOPHN's—Mrs. Hazel Thrasher, Arkansas; Olivia Hunsinger, California; Mrs. Gladys Garland, Georgia; Agnes O'Leary, Iowa; Christine Causey, Louisiana; Mabel Rue, Michigan; Louise Preston, Washington; Marie Scheffer, Wisconsin; Verle Baker, Utah.

Miss Houlton presented a report of NOPHN activities during the last quarter.

Report of the Treasurer. The Board accepted the report of the treasurer which showed net current assets in the general operating fund of $44,247.03, reserve funds of $39,418.21 or total net assets of $83,665.24; and life membership fund of $10,979.53. The Board approved the budget of $82,050 for the NOPHN project under American War-Community Services to develop needed public health nursing services for care of the sick in war communities. It was announced that American War-Community Services with strong backing from Community Chests and Councils is now launching a campaign for funds.

Report of the Finance Committee. In the absence of the chairman, Mary B. Spence, NOPHN business manager, gave the report for the Finance Committee. Among other activities this committee is considering a retirement plan for the headquarters staff and has a committee adjusting business staff salary scales to the present market.

In accepting the report of the Finance Committee the Board also approved its informal suggestion that money from the life membership fund which now equals almost $11,000 may be used at the discretion of the Executive Committee for carrying out postwar plans. No specific plan was presented but it is believed additional money for these activities will be needed and that life members will welcome having their dues spent for worthwhile purposes during their lifetime.

Approval of Skidmore College School of Nursing as preparing students for public health nursing. The Board confirmed a referendum vote taken in May approving the recommendation of the Education Committee that graduates of Skidmore College School of Nursing be considered qualified for first level public health nursing positions.

Joint Committee on Auxiliary Nursing Service. The Board approved the following recommendations of the Joint Committee on Auxiliary Nursing Service: (1) that the committee continue to participate in the activities of the working committee appointed by the U. S. Office of Education which is developing a suggested course for practical nurses based on a valid job analysis (2) that it make available to the working committee mate-

rials which have been prepared by the Joint Committee on Auxiliary Nursing Service of the three national nursing organizations (3) that it recommend appointment of state and local committees with representation from professional nursing organizations to work with state and local departments of vocational education that may establish courses for training of practical nurses (4) that the Committee participate in selection of young women for practical nurse schools.

Joint Advisory Committee to Give Attention to the Joint Survey of National Professional Nursing Organizations. The Board voted to approve the following recommendations of the Committee:

1. The Committee endorsed the report of a joint committee of the National Nursing Council for War Service recommending the establishment of a National Nursing Planning Committee to project a program for nursing at least five years into the future.

2. It recorded its belief that any plan for a joint survey of the professional nursing organizations must be based on a comprehensive study of program; hence the Committee could make no recommendations about a study at this time.

3. The Committee recommended that in the interim, the Headquarters Cabinet be instructed to study common activities of the national organizations and make suggestions for more effective and economical performance. Examples of common activities are: public information, personnel practices, conventions, bureau of publications, statistics and research.

Suggestions of the Cabinet would then be submitted to this Committee for consideration. Such consideration will help the Committee in its subsequent plan for the study of national organizations.

4. The Committee strongly recommended that the individual and joint boards emphasize to the National Nursing Council for War Service their opinion that the National Planning Committee be started immediately and that an adequate full-time staff be appointed to concentrate on the program.

Health Insurance. The Board approved the following recommendation presented by Marian G. Randall, chairman of the Committee on Nursing Administration:

The National Organization for Public Health Nursing expresses itself as favoring the expansion of health insurance plans and providing for nursing service including nursing care in the home. It is believed that in addition to voluntary effort, governmental assistance is necessary for attaining adequate distribution of health services.

This recommendation was later approved also by the NOPHN membership at its business meeting on June 6, and by the Joint Boards of the three national nursing organizations.

Formation of a section for nurse-midwives in public health nursing agencies. The Board approved of the formation of a section for nurse-midwives employed in public health nursing services. This action was taken on the recommendation of the NOPHN Council on Maternity and Child Health. Miss Hilbert, who presented the recommendation, stated that there are now about 100 nurse-midwives in public health, some of whom are already members of the NOPHN. They function largely as consultants to public health nurses in maternity service but in some states they also give direct service to patients. Helen Fisk of the Maryland State Department of Health is chairman of the NOPHN nurse-midwife committee which now becomes the Nurse-Midwife Section.

Wartime work week of the nursing staff at NOPHN headquarters. The Board considered a recommendation of the National Classification Committee of the National Nursing Council for War Service that "regardless of the number of hours their offices are officially open, the

working week of the nurses of all headquarters and regional staffs be extended to a minimum of 44 hours as a personnel policy as well as in actual practice." It was pointed out that due to the nature of their work, nurses of the NOPHN staff work more than 44 hours now but that NOPHN has long been on record as approving a 40-hour week for nurses and the written personnel practices of the NOPHN staff call for a work week not longer than this.

After discussion the Board voted to approve the 44-hour working week for nurse members of the NOPHN staff, with the provision that it is purely a war practice and that the 40-hour working week is still desirable for nurses in normal times.

RUTH HOULTON, SECRETARY
BOARD OF DIRECTORS

Resumé of Biennial Sessions

FOLLOWING a meeting of the NOPHN Board on Monday evening, June 5 (page 371), the opening business meeting was called to order by President Marion G. Howell on the morning of June 6. About 300 attended and 38 states answered the roll call. Miss Howell's report to the membership and those of General Director Ruth Houlton and Treasurer W. Lawrence McLane are published in full in the June 1944 *Phn: NOPHN News Bulletin,* as are also the biennial reports of the Council of Branches, standing committees, sections, councils, and joint committees. Copies have been mailed to all NOPHN members but extra copies are available at headquarters upon request. Because of limited time at the biennial business meeting, only three of NOPHN's important standing committees were asked to report on problems under consideration. Marian G. Randall, chairman of the Committee on Nursing Administration, spoke on the topic "Nursing in Health Service Plans" (page 311 this issue); Leah M. Blaisdell, chairman, Education Committee, on "Problems in Nursing Education" (to be published in a later issue of PUBLIC HEALTH NURSING); Horace H. Hughes, member of the Publicity Advisory Committee, on "The Nurse in Public Relations" (page 318).

Activities of the three NOPHN Sections—Board and Committee Members, School Nursing, and Industrial Nursing—which met June 6, will be reported upon in the August Magazine.

The Council of Branches met in all-day session on Wednesday, June 7, with Mrs. Mildred Hatton, Rhode Island, presiding in place of Chairman Adah Hershey, Iowa, who was unable to attend. During the morning session "Lay participation in SOPHN's" was discussed by Mrs. Wilkes P. Covey of Minnesota (see August Magazine) and Mrs. Stanley Stone of Wisconsin (page 355). General discussion of "present and future needs in public health nursing" followed, with Dorothy Carter, director, Boston Visiting Nurse Association, as leader. In the afternoon Marion Sheahan led the further consideration of "present and future needs" with emphasis on public health nursing responsibilities in the postwar period. Dr. Dean A. Clark told the group about federal-state vocational rehabilitation programs (page 345).

Directly after this meeting the NOPHN Membership Committee met for an exchange of views on membership problems (page 375).

Two joint meetings of the NOPHN, ANA and NLNE were held on the eve-

(Continued on page 380)

Emilie G. Sargent, Marion W. Sheahan, Mrs. David K. Ford, Ruth Houlton

NOPHN BOARD OF DIRECTORS

Officers—Terms expire 1946

PRESIDENT—*Marion W. Sheahan, R.N., Albany, N.Y.

FIRST VICE-PRESIDENT—*Emilie G. Sargent, R.N., Detroit, Mich.

SECOND VICE-PRESIDENT—*Mrs. David K. Ford, Shaker Heights, Cleveland, Ohio

TREASURER—*W. Lawrence McLane, New York, N.Y.

SECRETARY—*Ruth Houlton, R.N., New York, N. Y.

Directors—Terms expire 1946

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Mrs. Sumner Spaulding, Beverly Hills, Calif.

*Mrs. Langdon T. Thaxter, Portland, Me.

Dorris Weber, R.N., New Haven, Conn.

Nominating Committee—Terms expire 1946

Zella Bryant, R.N., Washington, D.C.

Laura A. Draper, R.N., Minneapolis, Minn.

Amy Louise Fisher, R.N., Raleigh, N.C.

Marie Neuschaefer, R.N., Des Moines, Iowa

Rosalie I. Peterson, R.N., New York, N.Y.

*Member of Executive Committee of Board.
**Vacancies filled by appointment.

NOPHN Membership 1944

AN OPEN MEETING of the National Membership Committee, combining serious discussion and singing in a lighter vein, was held Wednesday afternoon, June 7, following the all-day meeting of the Council of Branches. Emilie G. Sargent of Detroit, chairman, presided and announced that during the first five months of 1944, 9,489 nurses, and 724 non-nurses, or a total of 10,212 individuals had enrolled as members of the National Organization for Public Health Nursing. Of this total 108 are life members, 60 are sustaining members paying $10 or more annual dues, and 48 are public health nurses receiving complimentary membership because they are serving overseas. NOPHN also has 100 contributors and 349 agency members. Notification has been received of 471 former nurse members now in service, but it is estimated that at least twice or even three times that number are actually in service but have failed to notify the NOPHN.

Edith Wensley, secretary of the Membership Committee, stated that it was becoming increasingly difficult to locate members and asked both nurses and board members to inform headquarters if they change their address. She also asked agencies, if possible, to urge their nurses to do this.

A roll call of states followed. California, Colorado, Georgia, Kansas, Mississippi, New Hampshire, New Mexico, North Dakota, Tennessee, Utah, Wyoming, Hawaiian Islands and Puerto Rico all were reported as having an increase in membership for 1943. Other states reported a decrease in memberships because of an all-time high in turnover of personnel and because so many non-public health nurses are working in public health nursing organizations for the duration.

The value of joint membership between SOPHN's and the NOPHN was discussed. The consensus was that joint membership helps the NOPHN, but not always the SOPHN's. Some SOPHN's who now have joint membership with the NOPHN reported this type of membership keeps many people who are not nurses from joining the state organization because they feel they cannot afford both state and national dues. As it was felt that lay participation in state organizations is extremely important and that nothing should be done to jeopardize such participation, it was decided that joint membership is not desirable unless non-nurse members are ready for this step. However, it was also decided that all SOPHN's should continue to take just as much responsibility toward helping NOPHN secure members—both nurse and non-nurse.

The question of continuing the practice of awarding Honor Roll Certificates to agencies whose staffs have 100 percent enrollment in the NOPHN was next discussed. As these certificates incur considerable expense and clerical time, the question was raised as to whether or not this time and money could be spent for a more constructive promotion of membership. Members attending the meeting felt that the certificates had outlived their usefulness and that public health nurses joined the NOPHN for more significant reasons than merely to gain a certificate. It was voted to discontinue honor roll certificates but to send a thank-you letter

to all agencies having 100 percent enrollment and to continue listing their names in PUBLIC HEALTH NURSING Magazine.

Following discussion about the possibility of having one person in each state collect membership dues for all nursing organizations, the meeting adjourned and those attending joined a larger group for light refreshments and singing of topical songs. A group of Buffalo nurses and friends furnished a lively vocal leadership. Specially written songs included "The NOPHN Welcome Song" with words by Alice Abbott of the Buffalo VNA, "Lay That Pistol Down, Dear E-M-I-L-I-E" (addressed to the National Membership chairman), "Song of the 1944 Biennial," and "The Bag with the Towel on Top," reminiscent of "The Surrey with the Fringe on Top" and sung to that tune. The words to the latter song are included below.

THE BAG WITH THE TOWEL ON TOP

Public health nurse hurries off in a flurry
Hurries on her rounds without fear, without worry
The Little Black Bag all packed in a hurry
With the towel on top.
There're twenty-five thousand of her out this minute
Visiting homes, facto-rees, schools, and clinics
For our money, she's the tops, she's the pinnacle, yes, she's the top
She's everybody's friend, friend of everybody's friend
Friend of babies and of nice men
She loves her fellow men, she is very good to them
Sailors, pregnant ladies and the ice-man
Public health nurse, we are with you to the limit
Your brightly shining light, may fortune never dim it
You'll go on forever, and you'll never stop
With your Little Black Bag
With the towel on top.

Thirty-one mill-ion nur-sing visits,
In a good year she ne-ver miss's it
You would think she'd be quite dizzy, yet
She's always calm
To the Smiths and the Jones and the Wiggs and the Wiggins
Rosenburgs and Cohens, Bowens, Rowens, and the Riggins
She takes her little bag and its neatly managed contents
With the towel on top.

The deathrate's down and the birthrate's up
She knows how to do it
No measles, plague, nor plain milk leg
She helps them all eschew it
Public health nurse doesn't fret about the weather
Her shoes and her bag are genu-ine leather
Her dress is fast blue, her permanent is working and she never stops
With her Funny Little Bag
With the towel on top.

She hurries down street and she stops at the Jones'es
Mrs. Jones is off her feed and so is Mister Jones'es
Harry, Mary, Carry Jones have little things a'crawling
All around the top
Public health nurse says, "No, no" to the Jones'es
Dashes disinfectant on top the little Jones'es
Scurries next door where Mrs. Terry Moore
Is waiting patient-lee
The doctor's not there, his orders are clear
"No babies born without his confirmation"
With utmost tact, she puts the baby back
And thus saves the state of the nation.
Public health nurse, without her we'd be worse
We celebrate her fame in our song and in our verse
You can keep on wishing if you think we'd swap
For your Little Black Bag
With the towel on the top.

Reviews and Book Notes

PSYCHOSOMATIC MEDICINE: THE CLINICAL APPLICATION OF PSYCHOPATHOLOGY TO GENERAL MEDICAL PROBLEMS

By Edward Weiss, M.D., and O. Spurgeon English, M.D. 687 pp. W. B Saunders Company, Philadelphia, 1943. $8.

A comprehensive and well-presented exposition of a medical approach which is steadily gaining in recognition among both doctors and nurses is given in this book. The fact that emotional factors can influence physical illness is no new discovery. Precise studies, however, of the inter-relationship between physical and psychological factors in producing symptom-pictures have been few, and application of this knowledge in medical therapy has been rare. The orientation of the field of medicine has long been an organic one; personality and emotional problems have been considered the province of the psychiatrist.

Drs. Weiss and English, however, postulate that *all medicine is psychosomatic medicine* and therefore physicians must come to realize that psychopathology is often as important as tissue pathology in causing disease pictures. Practitioners of medicine must understand how to handle effectively the *psychosomatic* problem that almost every patient presents. It is not a matter of determining whether a given disease is functional or physical, but rather of demonstrating that "psychological and physical factors are both present and that the question becomes how much of the one and how much of the other and what is the relationship between them."

The material is organized in such fashion that by reading only six of the chapters designated by the authors the reader can get a general understanding of the subject and some basic principles of therapy. The intervening chapters deal with the various organic systems and the symptoms that may arise through the participation of emotional factors. The presentation is thorough and is supplemented throughout by many detailed and illustrative clinical histories.

Although primarily designed for physicians, this book should be of great value to nurses. We have heard much in nursing about caring for the patient as a personality and not as a disease picture. The information in this book should not only give the nurse a better appreciation of why this is important, but also enable her to give more effective and intelligent care.

EDITH PATTON
Norwich, Conn.

RELAXATION

By Josephine L. Rathbone. 157 pp. Bureau of Publications, Teachers College, Columbia University, New York, 1943. $1.75.

Relaxation is a timely book on the "how" and "why" of relaxing. Its forepart discusses tension, physical fatigue, and psychological fatigue, and what brings them about. Although the account of the physiology of fatigue and the chemical changes in muscles in fatigue is too technical for the average reader, the majority of the material in the first section is interesting and valuable to the lay person.

Physical and psychological treatments of fatigue are taken up in the second part of the book. Helpful suggestions are given as to rhythmic exercises for the release of tension and recommendations are made regarding play for adults. Dr. Edmund Jacobson's technique of training the muscles to relax at will is fully dis-

cussed.[4] Miss Rathbone emphasizes the fact that these suggestions for the relief of fatigue are not a substitute for medical advice when such counsel is needed.

People suffering from tension and chronic fatigue due to the stress and strain of present-day living will find this book helpful.

MARY GADACZ, R.N.
Salt Lake City, Utah

NUTRITION AND THE WAR

By Dr. Geoffrey Bourne, D.Sc. 148 pp. Cambridge: at The University Press; New York: The Macmillan Company, 1943. 2nd edition revised and enlarged. $1.60.

Designed primarily for the information of the English layman, the easy-to-read text of this book tells about food conditions in England and the use of foods available so as to protect health. Accompanying tables of food values and equivalents are so arranged that the one who plans meals will be able to make appropriate substitutes when any one food which occupies a prominent place in meal plans is unobtainable. These guides should tend to increase tolerance of the English housewife toward rationing, help to sustain her through this trying period, and inspire her with a determination to "come through" with the least possible harm to the health of her family.

The book will be interesting reading for anyone living in the United States but would be confusing as a nutrition guide in this country because of the differences in food habits, available foods, and the method of expressing nutrition standards.

LUCY H. GILLETT
New York, N.Y.

AN INTRODUCTION TO GROUP THERAPY

By S. R. Slavson. 352 pp. The Commonwealth Fund, New York, N.Y., 1943. $2.

The author discusses group therapy as employed by the Jewish Board of Guardians in New York City, a method of psychotherapy for children with problems of personality. Recognizing that healthy personalities are able to expand their group associations to include wider areas and larger numbers of persons, group therapy provides these dissocial children with a permissive environment in which their resistance to the world of associations is broken down and in which the participation in the group is at the same time the dynamics of therapy and the measurement of achievement.

Successive chapters give the principles and the practice of group therapy, the factors in forming groups and in selecting the group therapist, and the therapeutic process. The book is rich in case material, both in brief illustrations of theoretical points and in presentation of complete cases. The author makes the points that "group therapy cannot be considered a substitute for other types of psychotherapy," and that it "can be carried on only in an agency or clinic where psychiatric services are available for diagnostic purposes as well as for consultation and treatment."

Thus, the book has the most immediate and practical value to professional people who are interested in group therapy. However, other workers in the health and welfare fields will find it most helpful in developing an understanding of the problems of dissocial children, the help available through group therapy, and the vital meaning of such a resource in a community.

BARBARA BAILEY HODGES
Washington, D.C.

ROSE'S FOUNDATIONS OF NUTRITION

Revised by Grace MacLeod, Ph.D., and Clara Mae Taylor, Ph.D. 594 pp. The Macmillan Company, New York, N. Y., fourth edition, revised, 1944. $3.75.

For those who have been familiar with previous editions of this book there is little need for an introduction to this able revision, other than to say that the contents have been brought up to date. For those who have not made its acquaintance before, *Rose's Foundations of Nutrition* is planned for use in teaching nutrition to students with little background in the basic sciences. In the years since it first appeared in 1927 it has proved itself again and

again and has become one of the standard textbooks no nutrition teacher would be without.

The scope of the book includes a little of the historical background of the sciences of nutrition, a discussion of the basal metabolism and energy requirements, detailed discussions of the individual nutritive essentials (calories, proteins, minerals, and vitamins), separate chapters on the main food groups, and also individual chapters on the food needs of special age groups—adults, mothers and babies, children, adolescents—and adequate diets for family groups. In addition, the appendix contains much valuable tabulated material. The tables of food values, both in shares and weights, are particularly valuable for anyone working in this field.

One statement that might be questioned is on the controversial subject of the use of mineral oil in obesity diets.

Both Drs. MacLeod and Taylor are to be congratulated and thanked for making this well-seasoned textbook useful.

JULIA C. DWIGHT
New York, N. Y.

ORTHOPEDIC NURSING

By Robert V. Funsten, M.D., and Carmelita Calderwood, R.N., A.B. 502 pp. C. V. Mosby Company, St. Louis, 1943. $3.75.

Orthopedic Nursing is one of the most informative and readable additions to nursing literature. It contains a wealth of up-to-date, pertinent material covering brief discussions on orthopedic conditions, the scientific principles underlying their treatment, and how these principles may be integrated into all nursing services.

The nurse gains an understanding of the responsibility shared by the hospital and the public health nurse for the prevention, early recognition, and early and continued medical care of these conditions. She becomes aware of the important fact that because these patients usually need medical care over a long period the greater part of it must be given in the patient's home. She realizes the necessity for continuity of hospital care when the child returns to his home. The public health nurse senses the importance of her contribution toward maintaining or extending improvement obtained during hospitalization.

All nurses will welcome the inclusion of a brief explanation of mechanical factors and basic principles underlying the use of traction and other orthopedic appliances as related to specific conditions.

Visual aids in the form of simple graphs will be found of practical value to the teacher in correlating clinical and classroom discussions, especially in the hospital which does not have a special orthopedic service.

For the nurse desirous of acquiring a deeper knowledge of the orthopedic field, an extensive bibliography is given at the end of each chapter.

The introductory chapter, Toward a More Complete Understanding, is unusual and interesting—a challenge to the nurse not only in her acquisition of knowledge, but also in the application of such knowledge in relation to her daily activities. In other words, only by an intelligent, personal application of her scientific knowledge can the nurse become a convincing and dynamic health teacher.

In the concluding chapter, The Orthopedic Nurse and the War, the authors discuss war injuries and the newer methods of treatment. The nurse gets an insight into the orthopedic field of the future, a field for which additional or specialized preparation may be necessary to prepare her to play her part in meeting postwar nursing responsibilities.

Besides being a valuable asset in acquiring knowledge and skills in orthopedic nursing, this book may also serve in self appraisal of present efficiency, and as a guide for future preparation.

MARY FERGUSON
Indianapolis, Ind.

ENGLAND'S ROAD TO SOCIAL SECURITY: FROM THE STATUTE OF LABORERS IN 1349 TO THE BEVERIDGE REPORT OF 1942

By Karl de Schweinitz. 281 pp. University of Pennsylvania Press, Philadelphia, 1943. $3.

This is a digest of the social thinking and planning which brought England from the concepts of poverty and relief of the fourteenth century to the proposals for social security of the Beveridge Report of 1942. In its earlier parts, the book would be interesting to any reader. In its later parts, it becomes more definitely a summary and presupposes familiarity with the subject. The Beveridge Report receives special attention. The documentation seems excellent and the bibliography will be invaluable to students.

The author feels that British experience should contribute much toward making American social security legislation sound. No one could question this, but it is true also that this book leaves the definite impression that society is a living organism and that its evolutionary stages are reflected in the social legislation of a given group. At any rate, this summary contributes toward a broader understanding of the problem.

GERTRUDE ZURRER
Hartford, Conn.

PUBLIC HEALTH NURSING

RECENT PUBLICATIONS AND CURRENT PERIODICALS

MATERNAL AND INFANT CARE

INFORMATION FOR EXPECTANT MOTHERS. Metropolitan Life Insurance Company, 1 Madison Avenue, New York 10, N.Y., 1944. Revised. 34 pp. Free.

INDUSTRIAL NURSING

NURSING CARE OF EYES IN INDUSTRY. By Eleanor W. Mumford, R.N. *The Sight-Saving Review*. National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N.Y., Fall-Winter 1943. p. 165. Reprints 10 cents each.

GENERAL READING

BUDGET STANDARDS FOR FAMILY AGENCIES IN NEW YORK CITY. New York Budget Council, 105 East 22 Street, New York 10, N.Y., 1944. Second edition revised. 52 pp. 50 cents.

OPERATION STATISTICS OF SELECTED FAMILY CASEWORK AGENCIES 1943: SUMMARY OF STATISTICS REPORTED MONTHLY DURING THE YEAR TOGETHER WITH TREND DATA FOR THE PERIOD 1936 TO 1943. By Ralph G. Hurlin. Russell Sage Foundation, 130 East 22 Street, New York 10, N.Y., 1944. 27 pp. 25 cents. This study will be of interest to large agencies questioning their case and visit count bases.

TECHNIQUES OF LAW ENFORCEMENT IN THE TREATMENT OF JUVENILES AND THE PREVENTION OF JUVENILE DELINQUENCY. Compiled by the National Advisory Police Committee on Social Protection of the Federal Security Agency, Washington, D.C., 1944. 60 pp. Single copies may be obtained by writing the Director of Social Protection, FSA, Washington 25, D.C.

TEEN AGE CENTERS—A BIRD'S-EYE VIEW. National Recreation Association, 315 Fourth Avenue, New York 10, N.Y., 1944. 23 pp. 10 cents.

OUR CONCERN—EVERY CHILD: STATE AND COMMUNITY PLANNING FOR WARTIME AND POSTWAR SECURITY OF CHILDREN. By Emma O. Lundberg. U.S. Department of Labor, Children's Bureau, 1944. Bureau publication 303. 84 pp. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. 15 cents.

HEALTH EDUCATION

ARE WE SO MODERN? By Pattric Ruth O'Keefe and Aileen Carpenter. *The Journal of Health and Physical Education*. American Association for Health, Physical Education, and Recreation, 1201 Sixteenth Street, N.W., Washington 6, D.C., January 1944. p. 5. Reprints 5 cents each.

The results of a true and false test of 50 questions on fads and fallacies in health matters. The results show the influence of commercial advertising and tradition.

PUBLICITY

FEATURE ISSUE ON WARTIME PRINTING PROBLEMS. *Channels*. National Publicity Council for Health and Welfare Services, 130 East 22 Street, New York 10, N.Y., January-February 1944. 36 pp. 75 cents per single copy.

Biennial Sessions

(Continued from page 373)

nings of June 6 and 7 in the large Municipal Auditorium, at which reports were given on the nursing activities of the American Red Cross, the National Nursing Council for War Service (page 340), Procurement and Assignment, Division of Nurse Education, and the work of certain joint committees.

Institutes and conferences on school health, tuberculosis, health films, costs in nursing service, June 5 to 7, were well attended.

At the closing business meeting on Thursday morning, June 7, Section chairmen gave their reports (see August Magazine). The report of the Resolutions Committee was adopted (page 309). The Committee on Revisions reported proposed revisions to the By-laws were accepted without change (see April Magazine). The results of the national elections were reported (page 374).

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

1944 BIENNIAL

Registering at the 1944 Biennial Convention at Buffalo, June 4 to 8, were 1,888 nurses and friends of nursing, including 146 students. Nineteen of the 21 SOPHN's were represented and 173 representatives from NOPHN's 349 member and associate member agencies. Official representatives at the American Nurses' Association House of Delegates sessions numbered 944. Attendance was relatively small as expected since a large number of nurses could not be spared from their essential work at home and sessions were accordingly devoted exclusively to necessary business considerations of the three national nursing organizations. The 1942 Biennial at Chicago had an attendance of 10,766.

NEW GUIDANCE PAMPHLET

In response to an extensive demand for vocational material about public health nursing for the general public, the NOPHN Advisory Committee on Vocational Counseling and the Board and Committee Members Section with advice from vocational counseling leaders have prepared a new leaflet called "Your Career—Will It Be Public Health Nursing?"

This leaflet is the first of its kind that NOPHN has prepared, previous vocational leaflets having been directed almost exclusively to students in schools of nursing or to nurses in other fields. Written primarily for college women it is equally suitable for girls in high school and schools of nursing.

"Your Career" is proving very popular and is being widely distributed to colleges, interested individuals, agencies, selected magazines and publications, schools of nursing and other schools and organizations having vocational counseling services. Copies are free and available from the NOPHN headquarters.

ORTHOPEDIC SCHOLARSHIPS

The National Foundation for Infantile Paralysis has renewed its scholarship grant to NOPHN and NLNE to prepare supervisors in orthopedic nursing. For details write to the Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York 19, New York. Specially prepared nurses are now in great demand and will be even more so with the large rehabilitation program contemplated by the government and by voluntary agencies.

NOPHN FIELD NOTES

The aftermath of the Biennial and summer vacation schedules has brought a lull in NOPHN field service for June, July, and August. The following visits are scheduled:

Staff Member	*Place*	*Date*	
Mary C. Connor	Albany, N. Y.	June 10-11	Advisory service to Visiting Nurse Association
Ella Louise Gilmore	Bridgeport, Conn.	July 10-11	Advisory service to Visiting Nurse Association
Ruth Houlton	Washington, D. C.	June 22	Attend meeting of Children's Bureau committee
Mrs. Louise Lincoln	Ann Arbor, Mich.	July 3-22	Teach course in tuberculosis nursing at University of Michigan
Dorothy Rusby	Newport News and Hampton, Va.	June July	AWCS matters
Dorothy E. Wiesner	Moorestown, N. J.	June 22	Advisory service to Visiting Nurse Association

NOPHN HONOR ROLL

Hundreds more agencies have reported 100 percent staff enrollment in the NOPHN since the June magazine went to press. Limitations of space permit naming only 153 agencies this month. The rest will receive listing in the August issue.

ALABAMA

Montgomery—Metropolitan Life Insurance Nursing Service
*Troy—Pike County Health Unit

COLORADO

*Las Animas—Bent County Public Health Nursing Service
*Pueblo—City Health Department
Steamboat Springs—Routt County Nursing Service

CONNECTICUT

*Canaan—North Canaan Visiting Nurse Association
*Clinton—Public Health Nursing Association
*Darien—Public Health Nursing Association
*East Hampton—Public Health Nursing Association
*Fairfield—Visiting Nurse Association
*Glastonbury—Visiting Nurse Association
*Lakeville—Salisbury Public Health Nursing Association
*Meriden—Public Health and Visiting Nurse Association
*Naugatuck—American Red Cross
*New Britain—Visiting Nurse Association
*New Canaan—Visiting Nurse Association
New Preston—Visiting Nurse Association
Norwalk—Health Department
*Putnam—Red Cross Public Health Nursing Service
*Stratford—Public Health Nursing Association
Torrington—Metropolitan Life Insurance Nursing Service

FLORIDA

Chipley—Washington County Health Department
DeFuniak Springs—Walton-Okaloosa County Health Department
*Orlando—Metropolitan Life Insurance Nursing Service
*Pensacola—Escambia County Health Department
*Pensacola—Metropolitan Life Insurance Nursing Service
*Sanford—Seminole County Health Department

GEORGIA

Mount Vernon—Montgomery County Health Department
Savannah—Sugar Refining Corporation

ILLINOIS

*Cambridge—Henry County Sanitarium Board
*Carlinville—High School
Charleston—Public School
East Moline—Nursing Service
*Freeport—Board of Education
*Freeport—Stephenson County School Nursing Service
*Freeport—Stephenson County Tuberculosis Board
Gillespie—Metropolitan Life Insurance Nursing Service
Marseilles—Nursing Service
*Maywood—Board of Education, District 89
*Oregon—Ogle County Tuberculosis Sanatorium Board
Ottawa—Township High School, Board of Education
*Pekin—Community High School
Princeton—City School Health Service
*Springfield—Sangamon County Public Health Nursing and Tuberculosis Association

INDIANA

*English—Crawford County Public Health Nursing Service
*Fort Wayne—Tuberculosis Association of Allen County
*Huntington—City Schools
*Kokomo—Metropolitan Life Insurance Nursing Service
*Marion—Metropolitan Life Insurance Nursing Service
*Muncie—Visiting Nurse Association
*New Albany—Floyd County Tuberculosis Association
*New Castle—Public Health Nursing Association
Terre Haute—Public Health Nursing Association
*Terre Haute—City Schools, Hygiene Department
Tipton—County Public Health Nursing Service

IOWA

Ames—Board of Education
Boone—County Nursing Service
*Charles City—Board of Education
*Cherokee—Board of Education
Clinton—County Nursing Service
Davenport—Scott County Public Health Nursing Service
Decorah—District Health Office No. 1
*Des Moines—Iowa Tuberculosis Association
*Dubuque—County Public Health Nursing Service
Fort Dodge—Webster County Nursing Service
Guthrie Center—County Nursing Service
*Iowa City—Bureau of Dental Hygiene
*Iowa City—Public Schools
*Leon—Decatur County Nursing Service
*Knoxville—Marion County Public Health Nursing Service
*Maquoketa—Jackson County Public Health Nursing Service
*Marshalltown—Independent School District
*Oskaloosa—Mahaska County Nursing Service
*Ottumwa—Metropolitan Life Insurance Nursing Service
*Rockwell City—Calhoun County Nursing Service

KANSAS

*Arkansas City—City Nursing Association
*Emporia—Board of Education
Eureka—Board of Education
McPherson—County School Nurse
*Wichita—Tuberculosis Association
*Winfield—Board of Education

KENTUCKY

Brandenburg—Meade County Health Department
Columbia—Adair County Health Department

LOUISIANA

DeRidder—Beauregard Parish Health Unit
St. Martinsville—Parish Health Unit

MAINE

*Belfast—Waldo County Chapter, American Red Cross
Caribou—Maine State Bureau of Health, District No. 6
*Dover—Foxcroft—Piscataquis County Nursing Service
*Ellsworth—Hancock County Health Service
*Millinocket—School Health Service
Portland—Cumberland County Public Health Association
*Rockland—District Nursing Association
*Waterville—Metropolitan Life Insurance Nursing Service

MARYLAND

*Frederick—The Federated Charities
*Cambridge—Dorchester County Health Department
Cumberland—Metropolitan Life Insurance Nursing Service

MASSACHUSETTS

*Arlington—Visiting Nursing Association
*Boston—John Hancock Mutual Life Insurance Company

*On Honor Roll for five years or more.
**Staff and Board 100 percent enrolled.

*Fitchburg—Visiting Nursing Association
*Greenfield—Franklin County Public Health Association
*Quincy—Visiting Nurse Association
*Watertown—District Nursing Association

MICHIGAN
**Grand Rapids—Community Health Service

MINNESOTA
Cambridge—Isanti County Nursing Service
Cloquet—Community Nursing Service
Coleraine—School Nursing Service
Hopkins—Public School
Minneapolis—Industrial Nurse Service—The Dayton Company
Minneapolis—Department of Preventive Medicine and Public School, University of Minnesota
Minneapolis—Employers Mutual Liability Insurance Company
Minneapolis—United States Indian Service
Onamia—United States Indian Service
Proctor—Board of Education—School Nursing Service
Redwood Falls—School Nursing Service
Robbinsdale—School Nursing Service
St. Paul—The Golden Rule
*St. Paul—Ramsey County Nursing Service
St. Paul—Industrial Nurse—United States Post Office
Wabasha—Buena Vista Sanatorium

MISSOURI
*St. Louis—Visiting Nurse Association

MONTANA
Choteau—County Health Office

NEW HAMPSHIRE
*Groveton—Public Health Nursing Association

NEW JERSEY
*Camden—County Tuberculosis Association
*Maywood—Public School
New Brunswick—Visiting Nurses Association
Nutley—American Red Cross Public Health Nursing Service
*Salem—Child Welfare and Visiting Nurse Association
*Somerville—Somerset County Tuberculosis and Health Association

NEW YORK
Batavia—Infant Welfare Association
Bronxville—Public Schools
*Hempstead—Metropolitan Eastern Long Island Nursing Service
Nyack—Public Health Nursing Service
*Poughkeepsie—Dutchess County Health Association
Purchase—Nursing Committee
*Rochester—Visiting Nurse Association
*Watertown—Metropolitan Life Insurance Nursing Service

NORTH CAROLINA
*Burlington—Metropolitan Life Insurance Nursing Service
*Wilkesboro—County Health Department

NORTH DAKOTA
*Fargo—Nursing Bureau of Fargo Health Department

OHIO
Cleveland—Child Health Association
*East Liverpool—Department of Health
*Ravenna—Visiting Nurse Association

PENNSYLVANIA
*Fleetwood—Visiting Nurse Association
Kingston—West Side Visiting Nurse Association
Sharon—General American Transportation Corporation
Swarthmore—Community Health Society of Central Delaware County

RHODE ISLAND
*Carolina—Richmond Visiting Nurse Association
*Portsmouth—Public Health Nursing Service

TENNESSEE
*Nashville—Davidson County Health Department

VIRGINIA
Petersburg—Metropolitan Life Insurance Nursing Service

WEST VIRGINIA
Bluefield—Metropolitan Life Insurance Nursing Service

WISCONSIN
Kenosha—Metropolitan Life Insurance Nursing Service

HAWAII
Board of Health, Honolulu

AGENCY DUES

Since the June issue went to press 11 more member or associate member agencies have increased their NOPHN dues. These agencies are:

CONNECTICUT
Milford Public Health Nursing Association
Board Members Organization of Connecticut Public Health Nursing Associations

ILLINOIS
Evanston Infant Welfare Society
Moline Upper Rock Island County Visiting Nurse Association

INDIANA
Fort Wayne Public Health Nursing Services of Fort Wayne and Allen County, Inc.

MASSACHUSETTS
Winchester District Nursing Association

NEW YORK
Albany Visiting Nurse Association

OHIO
Hamilton Public Health League Nursing Association

PENNSYLVANIA
Lansdowne Public Health Nursing Service

RHODE ISLAND
Woonsocket Public Health Nursing Association

WISCONSIN
Neenah—Menasha Visiting Nurse Association

INCREASING residence changes on the part of many NOPHN members, necessitated in many instances by war exigencies, has loaded clerks at headquarters with the task of tracing addresses and remailing letters and materials returned to the office because of the changes in address. The amount of second class matter returned to headquarters has tripled in the war period and also the cost of handling it. Members and subscribers are urged to notify the National at once of changes in address—actual or contemplated—including the zone number. The latter is very important as the Post Office is becoming increasingly strict in its demand for this information. Any curtailment of routine clerical expenses will result in increased service to NOPHN members. Please help!

NEWS AND VIEWS

Highlights on Wartime Nursing

U. S. CADET NURSE CORPS

The Division of Nurse Education, USPHS, has begun to regionalize its operations, it was announced at the Advisory Committee meeting in Washington, June 1 and 2. The New York, Chicago and New Orleans field offices are scheduled to open in July. Each office will be under the supervision of a nurse education consultant. Working with her will be a public relations representative and an auditor.

Headed by Elsie Berdan, the New Orleans office is located in USPHS District No. 4, Pere Marquette Building, 150 Baronne Street. Included in this district are Louisiana, Alabama, Florida, Georgia, South Carolina, Mississippi, Tennessee, New Mexico and Texas.

Mary Jenney will direct activities in the New York office which serves Connecticut, Delaware, Maine, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island and Vermont.

The Chicago office will be under the direction of Jane Taylor. The states covered by this office include Illinois, Indiana, Kentucky, Ohio, and Wisconsin.

Appointments have not yet been made for the other Public Health Service districts.

The third meeting of the U. S. Cadet Nurse Corps Advisory Committee was held in Washington, June 1 and 2. Progress reports of the activities of the Cadet Nurse Corps since its inception under the Bolton Act were reviewed and plans considered for the coming year. Among the topics discussed were the problems of expanding schools and the lack of qualified teaching and supervisory personnel. Ways and means to meet these problems were examined. Marion G. Howell, former NOPHN president, was among the members of the Committee attending the meeting.

NURSES HELP OPA

The Nutrition Division of the New York City Department of Health has worked in close cooperation with the Regional Office of Price Administration, reports Mrs. Gertrude G. Mudge, head of the Division, on the dissemination of information on rationing, price control and rent control.

It was possible to transmit all this information to the 750 public health nurses who, beginning in January 1944, have been registered for 23 six weeks' nutrition refresher classes which have been given by the Division nutritionist. These nurses worked directly with the mothers and children in the child health stations in the public schools and in the homes. They reached an estimated number of over 300,000 families during the year. In order to help with the distribution of community ceiling prices on processed foods, each nurse was supplied with several copies of the price ceiling charts so that she might explain personally to the mothers with whom she was working the problems arising from price ceilings.

The nurses have also received OPA meat prices, information leaflets for schools and colleges, OPA bulletins for schools and colleges, Group Services bulletins and all other pertinent material. This information, in turn, they have been able to give to the individual family. At the nurses' own request they were also given copies of questions and answers on federal rent control as they reported that many questions were asked them in regard to rent problems.

PUBLIC INFORMATION PURPOSE

The statement of purpose that has been adopted by public information staffs in the national nursing organizations may be helpful to local public health nursing agencies in formulating their own public information programs, and in relating these programs to the interests of community nursing as a whole. That statement is: "The purpose of a public information program for nursing shall be so to interpret nursing that cooperation of nurses, related groups, and general public will be forthcoming to meet the immediate wartime needs and to give nursing

its rightful place and reward in an expanding program of service that will help all the people achieve positive health."

• Separation of the Henry Street Visiting Nurse Service from the Henry Street Settlement, and the formation of separate boards of directors to manage the two organizations was announced on May 24. The former will take the name, Visiting Nurse Service of New York, and will continue its offices at the present headquarters, 262 Madison Avenue, New York 16, N. Y. It will continue to provide nursing care for the sick in their homes in Manhattan, the Bronx, and Queens. Appointment of the new executive director of the Service, Marian G. Randall, was announced in the May magazine, page 258.

• *Public Health Nursing News,* new nursing bulletin of the Massachusetts State Department of Public Health, was introduced to the field in May 1944 with the issuance of Volume 1, Number 1. A monthly publication, 5½ x 8½ inches in size, 20 pages in length plus the blue covers, it is designed to carry news items from and about public health nurses throughout the state, changes in programs necessitated by the war and in personnel. Ethel Brooks, chief of the Public Health Nursing Service, requests the participation of readers in making suggestions for the bulletin, so that it may be of greatest interest to all.

• A leaflet for the use of state and local nursing councils for war service in approaching individuals and organizations for financial aid and other needed cooperation has been prepared by the National Nursing Council for War Service. "Nursing Councils for War Service Seek United Action" is the pamphlet's name and copies of it in any quantities are available to the state and local groups. Suggestions for the next edition of the leaflet will be welcome. Write the NNCWS at 1790 Broadway, New York 19, N.Y.

From Far and Near

• The School for Nurse-Midwifery of the Santa Fe Catholic Maternity Institute, Santa Fe, New Mexico, conducted by the Society of Catholic Medical Missionaries, Inc., is the latest nurse-midwifery school to be established in the United States. (See PUBLIC HEALTH NURSING, August 1943, page 477, for resumé to date of midwifery training in this country.) In providing this new school, the Institute hopes to decrease the maternal and infant mortality and morbidity in areas where adequate medical obstetrical care is not available to all mothers. Information for students, the curriculum listing, and expenses may be secured from the director of the School, 417 East Palace Avenue, Santa Fe.

• The Nursing Education Seminar Room in honor of the East Harlem Nursing and Health Service was dedicated at an informal tea held May 22 in Room 107, Dodge Hall of Teachers College, Columbia University, with the former co-directors of the Service, Grace Levering Anderson and Mabelle S. Welsh, as guests of honor. This comfortable seminar room with its accessible library of books on nursing and related subjects was furnished by friends, the board of directors and the staff of the East Harlem Nursing and Health Service.

• Fellowships for graduate work in health education for the fall term of 1944 are being offered to qualified American women by the U. S. Public Health Service through funds made available by the W. K. Kellogg Foundation. Women who are citizens of the United States between the ages of 19 and 40 years inclusive and who possess a B.A. from a recognized college or university may apply. Since the field is a relatively new one, no standardized training can be specified as a qualification. The fellowships lead to a master of science degree in public health and will provide 12 months' training in public health education; $100 a month for 12 months; full tuition and travel for field experience. The awards are to be made because of present and future needs for trained health educators in schools, communities and local, state and federal health departments. Write the Surgeon General, USPHS, Washington 14, D.C., for application forms. Applications, accompanied by a transcript of college credits and a small photograph, must be received not later than August 1, 1944.

Gonorrhea Increase—"As things are at present, we already have started toward the greatest epidemic of gonorrhea that our country has

ever experienced," states P. S. Pelouze, M.D., well-known urologic authority. Various reasons are given by Dr. Pelouze: (1) an overenthusiastic press has led the public to think that the new sulfonamide drugs have eliminated gonorrhea as a national problem (2) the rapid disappearance of symptoms under sulfa treatment has led to the assumption of "cure" in thousands of cases where the patient merely became asymptomatic while remaining infectious to others (3) the increase of sexual promiscuity which has always accompanied war has resulted in a wholesale spread of infection (the Armed Forces have reported to local health authorities, in connection with source finding, ratios varying between 7 to 30 cases of gonorrhea to 1 new case of syphilis).

Dr. Pelouze states that the trouble rests in the frequent differences between asymptomatic rates and true cure rates. Investigative groups have found as high as 32 percent positive gonococcus cultures in persons rendered asymptomatic by one course of sulfathiazole. There is no doubt that gonococci of these asymptomatics produce the disease when transmitted to other individuals. The duration of this carrier state in many patients is such as to offer us a terrific challenge in these days of ready assumption of cure because symptoms have disappeared. They call for patient control and patient instruction regarding the protection of others for far longer periods of time than generally are being carried out or advised. In no other way, Dr. Pelouze concludes, can we prevent the harvest of infection that is now in the making.

An increase of 11 percent in new reported cases of gonorrhea among civilians in the U. S. is revealed by the USPHS, based on a compilation of reports from state health officers covering the 6-months' period beginning July 1943. During the same time new reported syphilis cases dropped 16 percent.

For further details of the Pelouze statements, read *Venereal Disease Information*, March 1944.

Ringworm of the Scalp—An unprecedented spread of tinea capitis or ringworm of the scalp is occurring in New York, Philadelphia, Chicago and other communities according to reports published in the *New York Medical Journal*, June 15. Doctors Lewis, Silvers, Cipollaro, Muskatblit, and Mitchell were appointed by the Association of Dermatosyphilologists of Greater New York as a special committee to study problems connected with the epidemic of ringworm of the scalp now prevalent in New York City. (See also "An Epidemic of Ringworm of the Scalp," by Mitchell, Story and MacDonald, PUBLIC HEALTH NURSING, October 1943.)

Some of the possible causes of the spread are stated by the committee to be (1) decreased maternal care because of employment of mothers (2) widespread wartime migration of people (3) contacts in barber shops, moving picture houses, subways (4) overcrowding in children's institutions.

The conclusions reached in regard to the New York situation are applicable in other communities (1) a serious situation exists with an unknown number of cases (2) to control the epidemic, active cooperation between health department, dermatologists, clinics, and school authorities is essential (3) the disease should be made reportable, schools surveyed periodically, diagnostic clinics established where needed, the public informed (4) filtered ultraviolet rays are essential in case-finding and in tests of cure (5) infections caused by M. audouini should receive X-ray therapy as local measures are usually ineffective (6) communities free of the disease should take active preventive steps or localize any nidus which appears.

Attendance at Births—In spite of a total of 2,808,996 births recorded in the United States in 1942, the largest number in the history of the nation, more births occurred with medical attendance and in hospitals in 1942 than in any other year.

According to a special report recently released by the Bureau of the Census entitled, "Live Births by Person in Attendance, United States, 1942," 68 percent of the births were attended by a physician in hospitals, as against 37 percent in 1935, which is the first year of record. During the same period the percent attended by physicians but not in hospitals declined from 51 to 25 percent. The percent attended by midwives dropped from 11 down to 7 percent and those attended by "other and unspecified attendants" from 2 to 0.4 percent. There is a wide variation between states.

Between 99 and 100 percent of births were attended by a physician in 25 states in 1942. Births attended by midwives totalled 196,061 in the United States as a whole, ranging from none in 7 states and the District of Columbia and under 10 percent in 29 more states to between 13 and 46 percent in the 12 remaining states, all southern. Two percent of white births were attended by midwives, 46 percent of Negro, and 7 percent of births of other races.

Blue Cross Plan—Total membership in the Associated Hospital Service's 77 Blue Cross Plans throughout the country rose to 13,798,996 persons in the first quarter of 1944, exclusive

(Continued on page A8)